The Obstetric Gazette.

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Society Reports.

TRANSACTIONS OF THE OBSTETRICAL SOCIETY OF CINCINNATI.

Stated Meeting, September 13, 1883.

The President, Dr. J. Trush, in the Chair.

Dr. E. B. Stevens read the following paper on

THE MANAGEMENT OF ABORTIONS, ESPECIALLY WITH REFERENCE TO THE REMOVAL OF THE SECUNDINES.

In the number of the Obstetric Gazette for July, 1880, we contributed a brief article on this general subject growing out of a paper read to the Obstetric Section of the American Medical Association, at its meeting that year in the city of Washington, by Dr. J. Tabor Johnson. It will be remembered that the point made by Dr. Johnson had reference to the "removal of the placenta and membranes without delay. In other words, that the safety of the patient could only be assured when the uterus shall have been completely emptied." It was agreed that there was a largely prevailing sentiment in the profession to that effect—and yet we are satisfied that such view tends to the exercise of a good deal of "meddlesome midwifery." Indeed at that meeting Dr. Johnson's views did not meet with entire approval by any means; thus, Dr. Morris, of Baltimore, said: "He thought the placenta should be allowed to remain as long as no injurious effect resulted. Nature was quite competent to manage a great majority of cases of abortion occurring in the early stage of pregnancy. This matter of retained placenta he considered a needless bugbear in the eyes of the profession."

However, the principal points made in my paper at that time were intended to give expression to the vexatious and embarassing features liable to present in the management of these cases.

In that same number of the Gazette was a most excellent article on the same subject by Prof. Parvin, and, singularly enough, suggested, as was mine, by this same paper of Dr. Johnson.

He quotes, in the course of the paper, an old authority to the effect that "the three great remedies for abortion are rest, time and laudanum." And he further says that a long professional experience had confirmed him in the value of the advice. In another place he gives also this sig-

nificant anecdote of Dr. Fleetwood Churchill. Dr. Parvin says: "When that most amiable of Christian gentlemen, that wise and admirable teacher had gone with me just before I left Dublin, to Fannin & Co.'s, to select some obstetric instruments, I asked him for an ovum forceps. His reply was "your finger is the best ovum forceps." From which it will be inferred that Prof. Parvin is very conservative in cases of abortion and resorts to instrumental methods in the removal of the ovum or placenta with hesitation. In extreme cases, however, he details a method of dragging down the uterus with tenaculum forceps and removing the fragments of placenta with forceps. This, however, is not to our purpose at present; what we have just said is preliminary to another view of the matter, suggested by a paper of Dr. Walter Coles, read in the Obstetrical Society of St. Louis not long since and printed, with the discussion, in the *Courier of Medicine* for August last. That Dr. Coles may be the better understood, we go back a little:

In the *American Journal of Obstetrics* for February, 1883, will be found two articles on the management of abortions, especially the last stage. The first is by Dr. Alloway, of Montreal. He writes his paper for two reasons: 1st. "In recently published text-books on obstetrics, we find insufficient stress laid upon the importance of removing AT ONCE a retained placenta after abortion." *At once* is not only Italicised—it is capitalized. 2nd. "My wish to place before the profession the success which has attended the use of the dull curette or uterine scoop in my hands in such cases." Dr. Alloway discusses these two points in a very interesting manner, and illustrates his views with several cases in point.

In the same number of the *Journal* Dr. Mundé, the accomplished editor, contributes an article fully and to the extreme, endorsing Dr. Alloway. He says, and we desire to quote him in full: "I wish to add my testimony to that of Dr. Alloway *in favor of the forcible (that is, manual or instrumental) removal of the secundines immediately after the expulsion of the fetus, in every case where the cervical canal is sufficiently patulous to permit the introduction of the finger, or of a large dull curette or the placental forceps.* Further, *if there is hemorrhage, or an offensive vaginal discharge, or if the temperature rises, or if there is a chill, and the secundines are still retained, no matter how soon or how late, after the expulsion of the fetus, they should be at once removed, and, if necessary, the cervix dilated to facilitate the operation.* (Italics Dr. Mundé's). I have seen exhausting, almost fatal, hemorrhage continue for three weeks after a miscarriage, which was at once arrested on the removal of the retained placenta; and I have witnessed almost fatal septic infection come on within forty hours after expulsion of the fetus, and fatal septicemia from putrescence of the retained placenta, in spite of a temporary improvement after removal of that body on the fourth day. And I have seen women confined to their

beds by hemorrhage, or annoyed for weeks by sanguineous oozing worried in mind, and weakened in body thereby, all because the placenta had been left to "come away" by itself."

Now to return to Dr. Coles: It is with a view to controvert the views of Drs. Allowoy and Mundé, from whose papers we have just quoted, that he writes. After giving the substance of these papers, as we have attempted to do, Dr. Coles remarks: "Candor impels me to say that the doctrines inculcated therein are somewhat ultra and dangerous in their tendencies, being too dogmatic and sweeping in character, while at the same time they are lacking in fairness towards those who hold more conservative views." "Dr. Mundé, in endorsing Dr. Alloway, places all who would not advise the immediate chloroforming of a woman and "*at once*" and "*forcibly*" removing a retained placenta, as in favor of a "*let alone*" policy. Now this is by no means a fair statement of the attitude of our "*older confrères*," or of the less "*progressive*" among the younger members of the profession who are not *en rapport* with such advanced ideas. There is certainly a broad intermediate ground between "do nothing" and "*let alone*" policy and the heroic measures recommended by Dr. Mundé."

In the further details of his paper, he again says: "The testimony which these gentlemen bear to the utility of the curette and forceps is valuable, but that scoop or curette should be resorted to *primarily*, before *giving nature any voice in so important an affair*, certainly savors of rash practice, fraught with unnecessary suffering and pain."

The discussion of this paper was exceedingly interesting (as indeed the discussions of the St. Louis Obstetrical Society generally are). It was opened by that accomplished obstetrician, Prof. Boisliniere. He belongs to the conservative school and does not like to resort to the extreme measures that have been suggested. If he does not find the placenta within reach he leaves it for twelve hours at least. He then uses disinfectant injections and warm water to prevent septicemia. If there be hemorrhage or its danger he would use the tampon, apply iron to the cervical surface. He is opposed to the immediate use of the curette for the removal of the placenta—for while this removal with the aid of the curette may succeed with experienced obstetricians, it requires more experience than the ordinary physician had. In the menorrhagia that sometimes follows an abortion, whether due to the placental villi that remain, or to a diseased condition of the decidual membrane which produces a constant oozing, he thinks it is well to use the curette.

Dr. S. G. Moses did not think it right to use the amount of interference which is urged in Dr. Mundé's paper, whether there is hemorrhage or not. He had seen a great many cases of abortion, and did not think he ever saw a death result from this cause; he was sure he had not seen a death from the abortion alone where it occurred accidentally. Dr.

Moses is not favorable to the use of the tampon in these cases except for some special incidental reason.

Dr. Barrett was, if anything still more pronounced in his expression. He said he thought that a man who goes about scooping women's uteri because they have aborted ought not to be allowed to carry a curette. He regarded the finger as the best and only instrument which is necessary. It tells us what we are doing and what we have not done, and what remains to be done; it conveys to our minds exactly the information we need—the amount of force we are employing; none of this information can be gotten from the curette. He thought, furthermore, that the dangers of allowing the placenta to remain in the uterus is exaggerated; he would not be alarmed about a placenta remaining in the uterus twenty-four, thirty-six, or even forty-eight hours, if he had the patient under observation. There is a great deal of difficulty in removing the placenta in some cases after abortion, because it is so intimately connected with the uterus; but after the lapse of twenty-four or forty-eight hours, its immediate connection with the uterus begins to disintegrate, and the placenta comes away with perfect ease, when it was utterly impossible to separate it previously. The attending physician makes futile efforts to get the placenta away, and after a few days a consulting physician comes in and scoops it out and gets credit which does not belong to him because nature has done the work.

But to proceed with this interesting discussion, Dr. McPheeters held very much the same views as those already expressed. He thought a resort to instrumental methods was liable to produce traumatism; danger of injuring the parts; and even if successfully performed he thought inflammation was liable to be produced. To say that the placenta must be removed immediately in all cases is, he thought, going too far.

We have a great respect for the opinions of Dr. Mundé, and admiration for his admitted skill, but, as we at the same time think, his article as it stands, and as it will impress most of his readers, is calculated to do mischief—especially amongst the young and ambitious members of the profession. Hence we have thought it would be useful to make this review of these several papers and a synopsis of the discussion held in the Obstetrical society of St. Louis; its members, especially those quoted certainly ranking amongst the recognized leaders of the obstetric art in this country, and their opinions and experience are entitled to the most respectful consideration.

DISCUSSION.

Dr. Gustav Zinke considered the subject of sufficient importance not to be passed over lightly. He was satisfied that if this paper had been written by a man less known than Paul Mundé it would have received little, if any, attention.

His, the speaker's, experience—by no means a limited one—had

taught him that it was always wise to let "well enough" alone and that in nearly every instance that had come under his care, nature did the work alone. So far he had seen only one case that required the use of the curette, and that one to a limited extent only. He never saw a patient die from the effects of an abortion. In his earlier professional life he was often annoyed by the protracted nature of some of his cases; they were usually those in which the secundines were still retained. He was then in the habit of administering ergot, and as a result found, as he has convinced himself since, that, while it successfully stopped the hemorrhage for the time, it also contracted the uterus to such an extent as to securely lock within, and, for the present at least, prevent the expulsion of that which was still left within the womb.

Thus laboring under the impression that ergot will hasten the expulsion of the secundines it actually caused them to be retained and thus consideraly protact the case. Now he never thinks of giving ergot unless the uterus is empty or that the secundines have so formed (to a cone the shape of an egg) and are so situated within the cervix that contraction of the uterus could not possibly fail to expel them; and that will take place when the greater part of the conically shaped mass is found to be this side the external os.

Of late years when he finds that an abortion is unavoidable or in progress he pursues a different plan: besides perfect rest and the recumbent posture, agents, such as the bromide of potash, hydrate of chloral, or opiates are given internally, either singly or combined, while locally he irrigates the os with copious, oft repeated, very warm water injections.

The adoption of this mode of procedure was followed almost invariably by no untoward symptoms and the recoveries were more rapid than formerly.

He thought it highly improper and unnecessary—nay, even dangerous—to at once and in every instance adopt a mode of treatment as recommended in Dr. Munde's paper and perfectly agrees in every particular with the criticism of Dr. Cole.

Dr. Wright had read Dr. Mundé's article and was surprised at the line of argument taken in it. He was much pleased with Dr. Von Swearingen's position in the matter.

He would agree with Dr. Mundé in one respect, and that is where the ovum has been expelled and there is hemorrhage; he would endeavor to assist nature by using a limited degree of force, but would never resort to forcible extraction.

Where there is no hemorrhage he would let the secundines remain for a time until nature had done all she seemingly could and then attempt the removal by gentle dilatation with the fingers.

All that remains in the uterus after the expulsion of the ovum acts in

the nature of a foreign body and is an element of danger. We should not wait exclusively for the efforts of nature.

Dr. Wenning remarked that of late it appeared as if the medical profession were to be divided into two great armies on this question, one insisting on immediate—*forcible*—delivery of the secundines at all hazards, the other being content with waiting and depending on the *vis medicatrix naturæ*. If we are to judge from a certain number of cases as they present themselves in our daily practice, it is difficult to form a proper judgment which is the better plan, as good as well as bad results may follow each method of practice. For numerous cases are on record where the secundines have been retained an almost indefinite period of time without causing any injury, and on the other hand, unfortunately, too many cases are also on record where the retention of ever so small a portion proved fatal either rapidly or later on. Whilst, therefore, rather inclined to be conservative, he could not but help to admit, that in some cases an early removal of everything that may cause hemorrhage or septicæmia is peremptory. But once in a while an instance will occur in which it becomes a query what is to be done. He had some time ago a fatal case, and he had not yet been able to settle in his own mind the question whether death was the result of delayed interference or of too active treatment. (He would just here remark, that, at that time he had not yet read either Dr. Mundé's or Dr. Alloway's paper in the *American Journal of Obstetrics* of this year).

The patient, a young woman a little over 20 years of age, of robust and healthy appearance, and the mother of one child, was about four months advanced in pregnancy. She was suddenly attacked with hemorrhage for which the speaker was called, but in spite of closest search no ovum could be found, and he had to rely altogether on the report of the attendants for information. He was told that the lady had for some time since her first delivery been troubled with ulceration of the os for which a physician had applied iodoform locally, first himself, and afterwards directed the patient to apply it to the organ by her own hands. It was therefore not impossible, that, by this manœuvering she might have introduced some portion of this agent into the os and provoked thereby an abortion. But, be this as it may, the hemorrhage was soon controlled, and after a careful examination, although he was not able to enter the os, the speaker was confident that the placenta had not yet come away. He was, however, reluctant to interfere as there were no threatening symptoms and he preferred to wait for the expulsive efforts of nature to clear the uterus, in the meantime endeavoring to aid the contracting power of the womb by means of ergot. The third day the placenta was in the os and the speaker, by carefully circumscribing it with the finger, took it away, but he was not sure that he had removed it entirely as disintegration of the placenta had been considerable. In order therefore to pre-

vent, if possible, septicæmia, injections of carbolized water were freely made—or rather, continued, as they had been used from the start—but in spite of this treatment fever came on the next day. He therefore, scraped the walls of the uterus with the curette, in the meanwhile continuing his antiseptic injections, and prescribed quinine and whisky freely. Notwithsanding all this the fever continued, the temperature rising very rapidly, a fearful diarrhœa set in and the patient finally died on the ninth day.

The question now arises, should the placenta have been removed immediately and forcibly, or should the curette not have been used? The speaker would offer one criticism to his treatment and that was the use of ergot. He now believes that it should have been omitted altogether as its contractile power affects the muscles of the neck as well as those of the body of the womb, and consequently by constricting the cervix it retards rather than promotes the expulsion of the contents of the uterus. He, therefore, now believes in the doctrine that, with rare exceptions, ergot ought not to be used until after the expulsion of the placenta.

Dr. Geo. E. Jones suggested that it might be possible that the fœtus had been dead some time when Dr. Wenning first saw the patient, and that she was already threatened with septicæmia. He did not believe that any law could be laid down which would cover all cases. He had no fear of hemorrhage for he believed it always controllable.

In regard to the use of force he was strongly opposed to it. If it will come with gentle movement, remove it at once; if it will not, let it alone. There is, in his experience, no danger in delay.

Dr. Trush thought the subject under discussion was one of the very greatest importance to the obstetric practitioner; not only were abortions of frequent occurrence, they led but too often to most deplorable results; and yet, notwithstanding the importance of the subject, no settled opinion, respecting the best mode of managing these cases, had so far been developed. Why was this? It could not be because too little attention had been bestowed upon this topic for quite the contrary was true. The diversity of opinion, most probably arose from the fact that bad results had followed in the wake of every known procedure and also, perhaps, because no *one* plan of management was adapted to all cases. The essayist had referred to the two extremes of treating abortions; the one saying: remove any remaining contents of the uterine cavity at once—curette if necessary but remove them; the other crying, don't! you will surely kill your patient, if you do;—leave it all to nature. Amid such conflicting, authoritative, advice the ordinary practitioner might well feel confused, scarcely knowing which way to turn. Fortunately, there was a large middle ground of action; one was not necessarily compelled to wholly adopt either extreme; in this respect he was fully in accord with previ-

ous speakers that, a selective course was probably the safest and the best. But in thus selecting, the one, cardinal fact should always be kept in remembrance, viz., that no aborting woman was fairly *safe*, until the entire products of the conception had been discharged. Until this was accomplished the patient might, at any moment, be seized with an alarming hemorrhage, or, later, fall a prey to septic infection. The therapeutic indications were therefore perfectly clear, and to the effect, that, our best endeavors should always be used to *fully clear the uterine cavity;* but, manifestly the means employed must be of a character not liable to do more harm than good. With this view of the subject, he was in the habit of resorting to digital removal of any retained portions of the ovum, he even employed the placental forceps for seizing and removing detached fragments which he had failed to secure with the fingers; this he did at once, or as soon as possible, after extrusion of the fœtus, being desirous to take advantage of the open state of the os and cervix, an opportunity which at a later period would probably be lost. The farther the patient had been advanced in her gestation the more determined were his efforts to fully evacuate the uterine cavity; after the middle period the same rules, he thought, held good respecting this particular, as in labor at term. But if on arrival at the bedside he found the os and cervix already closed, then he adopted one of two plans of treatment, according as the case *was*, or *was not*, complicated by hemorrhage. In the former event he had recourse to cervical tents with small vaginal tampon as support; removing and readjusting the same as the exegéncies of the case might demand. In the latter condition he remained entirely passive, simply watching his patient and interfering only when compelled by reason of hemorrhage and then his procedure was that already delineated. If in any case symptoms of decomposition of retained secundines, etc., were present, he likewise abstained from all attempts at forcible removal, excepting the withdrawal of any loose fragments overlying the os, limiting his action to the employment of local disinfectants in the form of vaginal and uterine douches and the internal administration of some of the usual, so-called, antiseptics, and only if compelled by reason of hemorrhage did he resort to active interference and then after the manner indicated in aseptic cases. He should feel very loth to employ the curette under such circumstanes, fearing that the sudden "wholesale" introduction of septic matter into the general circulation, almost certain to take place, upon the creation of the great number of fresh wounds, might overwhelm the organism and lead rapidly to a fatal termination. Although so far he had had no occasion to regret having pursued this semi-conservative course of treating abortions, he would freely confess that he never felt at ease in any case of this kind, until he knew the uterine cavity to be entirely cleared of the whole products of the conception.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

Stated Meeting, Thursday, September 6th, 1883.

The President, R. A. CLEEMANN, M.D., in the Chair.

Dr. Wm. T. Taylor read the report of a case of

FACE PRESENTATION WITH ECLAMPSIA.

Face presentations are somewhat rare. Dr. Churchill some years ago, in recording the statistics found, that in British practice they occurred once in 292 cases; in the French practice once in 275, and in German practice once in 130 cases. In my own practice I have met with about one dozen, and as the last one was combined with eclampsia I will report it to the Society.

During utero-gestation my patient enjoyed very good health, having no headache, no swollen limbs nor bloated features, no vertigo nor dimness of vision. There was no deficiency of urine, and therefore I did not examine it for albumen. Her appetite was fair, her bowels regular, and she took a moderate degree of exercise; so that I had no reason to expect any trouble when labor began.

On May 14th, 1883, I was summoned, at 6 a.m., to visit Mrs. C. Haley, aged 23 years, primipara, who was in the first stage of labor, having had a show since midnight. On examination I found the os very slightly dilated with the pains "few and far between" and the face of the child presenting, with the chin toward the sacrum. The nurse informed me that the patient had not slept during the night and was very nervous and irritable. Her skin was moist, her pulse normal, and she had urinated frequently.

I gave her a mixture containing hydrate of chloral, bromide of potassium and valerinate of ammonia to compose her, and went home for my breakfast intending to return in a few hours.

At 8 o'clock the husband came to my office and told me that his wife had "had a fit and could not keep the medicine down." I arrived at the house at 8:30 a.m., and sent immediately for some powdered hydrate of chloral and an injection apparatus. The patient had had two convulsions which were ushered in by complainings of the head, her face being very red, and her head drawn to one side with the features much distorted. The first convulsion occurred when the nurse was about to give the first dose of the medicine. Directly after my arrival a third convulsion occurred and lasted for a minute or more, her head being violently drawn to the right side, with jerking of her arms and legs.

I dissolved one drachm of the hydrate of chloral in about four ounces of water, and threw it into the rectum. The fit yielded immediately. As she was unconscious I had an excellent opportunity of examining her. The os was dilated to the size of a quarter of a dollar, and soft so that it yielded gradually to the pressure of my fingers, when I discov-

ered the face presentation with the chin toward the left sacroilliac junction. I endeavored to push the chin toward the breast so as to bring down the occiput in the second position of Baudelocque. This I found somewhat difficult, but as the os dilated under the pressure of my fingers, I reached the occiput and after several attempts succeeded in bringing it down to a favorable position, the one aforesaid. My patient by this time was becoming restless and uncontrollable and fearing another convulsion, I again gave her an injection of chloral which quieted her. Having placed her on her back and brought her to the edge of the bed, her limbs being supported by the nurse and a neighbor woman, the forceps were easily applied and the head brought down below the inferior strait. I removed the instruments when the head pressed against the perineum allowing nature to finish the delivery. The child, a boy, was still, the cord being pulseless. In fact I was apprised of this whilst endeavoring to dilate the os with my fingers, for a significant tremor had passed through the body of the child assuring me of its death. The placenta was removed quite easily.

During all this time my patient was unconscious and had no return of convulsions from the time I gave her the first injection of chloral.

As her pulse was good and her respiration easy, I applied a binder, and having placed her in a comfortable position left her sleeping. On my return at 5 p.m. she was restless and slightly feverish, but after taking a few doses of chloral and valerian she was quieted to sleep. On the next morning, May 15th, she was perfectly conscious, pulse, 80; temperature, 99°; and respiration normal. She had urinated freely, and with the exception of some slight soreness over the abdomen, was very comfortable. She inquired for the babe, knowing from her condition that it had been born; but the preceding 24 hours were, to her, a perfect blank. From this time she had no further trouble, and soon recovered. This case certainly showed the beneficial effect of injections of hydrate of chloral in controlling puerperal convulsions when they are of a nervous form.

DISCUSSION.

Dr. Albert H. Smith remarked that face presentations and puerperal convulsions presented a large field for discussion. Dr. Taylor was very fortunate to be able to bring down the occiput and keep it so until the forceps could be applied. In this operation a man needs three hands, one to hold the head while the others manipulate the instrument. The mechanism of a primary face presentation, as reported in this case, is difficult to understand. It may occur secondarily from obliquity of the uterus and a sudden, free gush of waters, causing a sudden engagement of the head before flexion could be secured. In such cases it is very difficult to secure and maintain flexion until the forceps can be applied. In the majority of cases of face presentation, even with the chin posterior,

nature is best able to terminate the case satisfactorily. It is to this class that the aphorism, "meddlesome midwifery is bad," is most applicable. The natural forces work slowly and the neck of the child becomes accustomed to the extreme extension which it has to undergo; while it is very bad to bring, by means of the forceps or otherwise, a sudden strain on the vertebræ and other tissues of the neck by too rapid forcing of the the chin into violent extension. The consequence of the hasty proceeding is a still-born child. The only ground for interference is an alarming condition of the child's pulse. If the child's heart is beginning to fail we must take the risk and give it the benefit of the chance. The child's head cannot be born in face presentation until the chin has engaged under the pubis. The old teaching was the chin posterior could not be born, but he was very early undeceived in this point, one of his earliest cases having been of this character. He had sent for his perceptor to come and bring perforating instruments, but while awaiting their arrival, nature proved equal to the task, rotation occurred spontaneously and a living child was born.

Dr. B. F. Baer inquired if version by the feet would not be much preferable to waiting for nature to deliver in chin posterior positions.

Dr. Smith did not mean that we should never interfere in a case of this kind, but that a large majority, if left to nature, would terminate spontaneously by anterior rotation of the chin, with safety to both mother and child. He would decidedly negative the proposition of version by the feet, because the amniotic sac having been necessarily ruptured by previous efforts to bring down the vertex, the waters should have been completely evacuated, the uterus would be in a condition of spasmodic contraction, and an attempt to turn would involve great danger of rupture of the uterus. The introduction of the hand always increases the risk of septic absorption. Two terrible risks against the mother while the child is exposed to all the dangers of head last delivery. He should consider chin posterior presentations, natural labors, and should allow them to terminate spontaneously unless there was some complication demanding version.

Dr. J. G. Allen coincided with Dr. Smith in his conservative principles. The risks of version to the mother are great, too great to allow it to be performed for the sake of the child. The operation of version is not looked upon in as serious a light as it should be under all circumstances. In some instances it may be very easy, and may terminate well, but in others, apparently similar in conditions, the results to the mothers are bad. He would not lose one mother to save ten children. He would never resort to version unless the labor was impossible under other measures. Even after it is skillfully performed the child is often still. The increased risk to the mother is followed by no corresponding gain in safety to the child.

Dr. R. P. Harris thinks the ideas of Dr. Smith are the same as held by most eminent obstetricians and agrees with their practice as expressed to him in private correspondence.

Dr. Baer was willing to be taught. The views expressed this evening did not harmonize with the teaching of even the present day in Philadelphia. He had been taught that version would be proper if the case was diagnosticated early and the operation could be performed before the waters were evacuated and it seemed to him that the rational thing under such circumstances would be to turn. It was entirely a new light to him to consider chin posterior cases as easy natural labors. He had been taught to look upon them as impossible and that rotation never took place, the forces in action not being great enough to compel it. His own recent experience had led him to doubt this dictum; with one blade of the forceps used as a vectis he had without difficulty secured anterior rotation. His idea of the impossibility of rotation under the circumstances made him doubt the correctness of his diagnosis of the position, but the principles put forth this evening reassured him. May the death of the child, causing relaxation, be the cause of the face presentation?

Dr. Allen does not expect others to accept his opinion, but in his denunciation of turning he alludes to the complete transposition of one extremity of the fœtal elipse for the other and does not include the changing of one part of the head for another, but in the first class the poor chance of saving the child will not compensate for the increased danger to the mother.

Dr. Smith does not consider chin posterior an easy natural labor. On the contrary it is the most difficult of natural labors. The chin strikes upon the posterior inclined planes and is rotated to an anterior position, in which it engages under the arch of the pubis exactly as the vertex would. In multipara nature is able to accomplish this result, but in primipara assistance in rotation may be required and even traction become necessary. In contrasting the dangers incident to version by the feet and those involved in trusting to nature in this condition where the waters have been discharged, as they necessarily have, in the attempts to bring down the vertex, which will be the first tried, we must remember that the child will be tightly grasped by the uterus and that it must be twisted upon its long axis as well as turned, to bring the nape of the neck under the arch of the pubis, and that this procedure will greatly enhance the danger to both mother and child.

Dr. Taylor in closing the discussion remarked that the death of the child occurred after it was fully engaged and was not a factor in causing the face presentation. When he made his diagnosis of position the head was high up, and the child being small he had no difficulty in bringing down the vertex.

W. H. H. GITHENS, M.D., Secretary.

AMERICAN GYNÆCOLOGICAL SOCIETY.

The eighth annual meeting was held in the hall of the College of Physicians, in Philadelphia, Tuesday, Wednesday, and Thursday, September 18, 19, and 20, 1883, the President, Dr. Gilman Kimball, of Lowell, Mass., in the chair.

FIRST DAY—MORNING SESSION.

The meeting was called to order at 10.30 a.m.

The following-named Fellows were present during the day: Dr. Gilman Kimball, of Lowell, Mass.; Dr. Fordyce Barker, of New York; Dr. Robert Battey, of Rome, Ga.; Dr. B. B. Browne, of Baltimore; Dr. William H. Byford, of Chicago; Dr. John Byrne, of Brooklyn; Dr. Henry F. Campbell, of Augusta, Ga.; Dr. James R. Chadwick, of Boston; Dr. Edward L. Duer, of Philadelphia; Dr. Thomas Addis Emmet, Dr. Frank P. Foster, and Dr. Walter R. Gillette, of New York; Dr. William Goodell, of Philadelphia; Dr. William T. Howard, of Baltimore; Dr. James V. Ingham, of Philadelphia; Dr. Reeves Jackson, of Chicago; Dr. Joseph Tabor Johnson, of Washington; Dr. William T. Lusk, of New York; Dr. George H. Lyman, of Boston; Dr. Matthew D. Mann, of Buffalo; Dr. C. D. Palmer, of Cincinnati; Theophilus Parvin, of Philadelphia; Dr. Thaddeus A. Reamy, of Cincinnati; Dr. John C. Reeve, of Dayton, O.; Dr. John P. Reynolds, of Boston; Dr. Albert H. Smith, of Philadelphia; Dr. R. Stansbury Sutton, of Pittsburg; Dr. Ely Van de Warker, of Syracuse; Dr. H. P. C. Wilson, of Baltimore; and Dr. E. Wilson, of Philadelphia.

The Address of Welcome was read by Dr. Edward L. Duer, of Philadelphia, who dwelt briefly upon the scientific importance of the annual meetings, but emphasized also the value of the social element.

Invited Guests.—On recommendation of the Council, the following-named gentlemen were invited to attend the meeting as guests of the society: Dr. Alfred Stillé, president of the College of Physicians of Philadelphia; Dr. William M. Welch, president of the Philadelphia County Medical Society; Dr. Richard A. Cleeman, president of the Obstetrical Society of Philadelphia; Dr. James Tyson, president of the Pathological Society of Philadelphia; Dr. Robert P. Harris, of Philadelphia; and Dr. I. R. Page, and Dr. Robert T. Wilson, of Baltimore.

SUPERINVOLUTION OF THE UTERUS.

Dr. Joseph Taber Johnson, of Washington, read a paper with this title, in which, after summarizing the writings of Sir J. Y. Simpson and other authors upon the subject, he embodied notes of four cases that he had met with in his own experience. Care should be taken not to confound such cases with those of atresia of the uterine canal. General invalidism was not a necessary result of the lesion, as was shown in one of the cases narrated, in which the patient appeared to be in blooming health. In

cases in which there was impairment of the general health, the use of galvanism, ergot, strychnine, and various tonics would correct that condition, but the problem was, to restore the uterine functions to their normal condition, and especially to overcome sterility. In this attempt the author's experience had not been encouraging. In one instance phenomena resembling the early signs of pregnancy followed, but they proved illusory, and impregnation was found not to have taken place. Dr. Johnson was not inclined to agree with Dr. Walter Coles, of St. Louis, in considering the lesion to be properly one of post-partum atrophy, rather than of superinvolution. In the treatment, galvanic stem pessaries were recommended by many authors, but it was admitted in general that restoration of the organ to its natural condition could not be accomplished, in marked cases, by this or any other measure.

Dr. Fordyce Barker, of New York, remarked, in regard to the term "superinvolution," that he thought it might properly be applied to excessive involution after enlargement of the uterus from any cause, as from fibrous tumors, and need not be limited to the hypertrophy due to pregnancy. It was difficult to estimate the frequency of its occurrence, but he saw from one to three cases every year—mostly in consultation. In deciding whether or not, in any given case, there was a chance of producing improvement by treatment, he had been in the habit of guiding himself by the state of the ovaries in regard to the function of ovulation. If there were well-marked signs of ovulation, the prognosis was reasonably good. The speaker related cases illustrating this statement.

Dr. A. Reeves Jackson, of Chicago, had seen but a single case, and that of doubtful diagnosis, and had been surprised to find now that the occurrence of the condition was considered so common. In his case there was stenosis of the uterine canal. The use of a galvanic stem pessary for several months was productive of no benefit. The speaker was inclined to regard Dr. Barker's suggestion as to the prognosis as of very great practical importance.

Dr. Ely Van de Warker, of Syracuse N. Y., called attention to the frequency of superinvolution limited to the cervix, due, in his experience, to laceration of the cervix, and generally confined to the posterior lip. Perhaps the lesion was due to cicatricial contraction.

Dr. H. P. C. Wilson, of Baltimore, had rarely met with superinvolution following gestation—not more than two or three times in his whole practice. Dr. Barker's view as to prognosis commended itself to him, and had been borne out in his experience.

Dr. Robert Battey, of Rome, Ga., spoke of superinvolution as a very common result of oöphorectomy, often very marked in degree. Lack of proper ovulation was, he thought, the cause of the trouble in the class of cases referred to by the reader of the paper. He could not agree with Mr. Lawson Tait in regarding the ovarian function as of little governing

importance in the physiology of menstruation. In regard to treatment, he had found electricity, passed from the sacral region through to the iliac region or the vagina, the most beneficial agent, and with its use he usually combined dilatation of the uterine canal with tents.

Dr. William H. Byford, of Chicago, was inclined to regard superinvolution as one of the stages of atrophy. We should distinguish, too, between diminution of the size of the utereus alone and such reduction associated with other atrophic or senile changes in the pelvic organs, especially the ovaries. In simple uterine cases, stimulation by some foreign body might be productive of benefit.

Dr. Henry F. Campbell, of Augusta, Ga., did not think the condition was necessarily due either to the discontinuence of ovulation or to atresia. He had known it to result from over-distention of the uterus due to dropsy of the amnion, of which he related an interesting example. This result, he thought, was due to injury to the muscular structure, as happened to the bladder in cases of over-distention.

Dr. Johnson closed the discussion by expressing his agreement in the view as to prognosis given by Dr. Barker.

The Importance of Cleanliness in Surgical Operations.

was the title of the next paper, by Dr. R. Stansbury Sutton, of Pittsburg Pa. The author drew a striking picture of the effects of surgical methods in vogue prior to the past twenty-five years in thwarting the efforts of nature in the repair of injuries. The ancients governed themselves by the theory that everything bad came from within; consequently, purgation of one sort and another was thought to be of the first necessity. We, on the other hand, regarded the malign influences acting upon wounds as derived from without, and took all possible pains to exclude germs and to maintain scrupulous cleanliness. Reviewing the chief modifications of the Listerian method of treating wounds, and according full credit to the method, the author thought it abundantly established, by the experience of Dr. Keith, Mr. Tait, and Mr. Bantock, that, in some of its features at least, it was better to modify it in abdominal surgery. Those who found great advantages in Listerism were those whose practice before they had adopted it was not characterized by the cleanliness that was one of its cardinal points; those who regarded it as of no assistance were those who already paid so much attention to cleanliness that they did not stand in need of the improvement it involved. A specific dressing was not needed in all cases; cleanliness, however, should always be secured. The reader then gave detailed directions for the maintenance of cleanliness.

At the suggestion of Dr. Barker, Dr. S. D. Gross, of Philadelphia, was invited to open the discussion, but declined to do so.

Dr. Thomas Addis Emmet, of New York, was fully aware of the neces-

sity of cleanliness. He placed more reliance on soap and water than on any germicide.

Dr. William T. Lusk, of New York, thought Dr. Sutton's directions as to cleanliness would satisfy the most ardent supporter of Listerism. He could not admit that the spray was so useless or so dangerous as it was getting to be common to represent it. In operations upon parts reached through the vagina, the advantages to be derived from preliminary disinfection of the vagina were most decided. Some years ago the speaker did the first successful ovariotomy done in Bellevue Hospital—and in a surgical ward—relying on Listerism. In this "tainted hospital" he still performed ovariotomy without hesitation, and with good results, thanks to Listerism.

Dr. H. P. C. Wilson coincided with Dr. Lusk's views in regard to Listerism and to the spray. It was somewhat disingenuous, he thought, for the great ovariotomists to decry Listerism, while daily using all of Mr. Lister's precautions. barring the spray.

Dr. Campbell was not aware that his operations had resulted any better since he had adopted Listerism than before. Even cleanliness he regarded as overrated.

Dr. Sutton could not admit that the operators he had cited were in the habit of resorting to Listerism, all but the spray, for no specific germicide was used, but cleanliness only. Whatever good was to be attributed to the spray was, he believed, due to its wetting the germs, thus causing them to fall to the floor, rather than to its killing them; and no doubt pure water would accomplish the same purpose, whether in the form of a spray, or delivered from a sprinkling-pot, or thrown on the floor with a broom.

AFTERNOON SESSION.

On recommendation of the Council, the following-named gentlemen were added to the number of invited guests: Dr. Samuel D. Gross, of Philadelphia; Dr. R. B. Maury, of Memphis, Tenn.; Dr. William E. Moseley and Dr. William P. Chunn, of Baltimore.

Hot Water in Secondary Hemorrhage After Pelvic Operations.

Dr. Albert H. Smith, in a paper with this title, spoke of the prominence that Dr. Emmet's teaching had given to the use of hot water as a hemostatic, Dr. Emmet having, in turn, credited the late Dr. Pitcher, of Detroit, with originality in the matter. Ever since Dr. Emmet's first publication on the subject, Dr. Smith had made use of the measure in a wide range of cases, and with the most satisfactory results. Indeed, it had become so much a matter of routine that he would not have thought of making it the subject of a paper but for the fact that he had reason to believe that in some quarters it was not yet appreciated. His attention had recently been directed to the fact by a lecture given by Dr. Skene,

of Brooklyn, in which mention was made of cases of secondary hemorrhage, after operations, managed by manipulative interference which imperilled the full success of the operative procedures. Cases were related illustrating the efficiency of hot water under such circumstances.

Dr. Thaddeus A. Reamy, of Cincinnati, corroborated Dr. Smith's views, and stated that for many years he had had hot water poured on the perineum during the operation for laceration, instead of using sponges.

Dr. James R. Chadwick, of Boston, and Dr. William Goodell, of Philadelphia, coincided in Dr. Smith's views.

Dr. H. P. C. Wilson would emphaize the advantage of hot water in post-partum hemorrhage. He also mentioned a striking instance of its beneficial action in a case of profuse hemorrhage during vaginal oöphorectomy.

Dr. Campbell preferred to depend on diluted tincture of iodine as a hemostatic, as recommended by the late Dr. Trask, but did not doubt the efficacy of hot water.

Dr. Matthew D. Mann, of Buffalo, had not found the use of hot water always successful. He had never had occasion to use it in secondary hemorrhage; but, in a case of primary hemorrhage during the removal of a cancerous cervix, hot water proved of no avail. In that case, vinegar also failed, likewise the actual cautery and a firm iron tampon, and death resulted very speedily. An artery had been divided.

Dr. Goodell thought nothing could be expected of hot water or any other hæmostatic in such a case as Dr. Mann's, but, in cases of oozing, hot water had some advantages over other hæmostatics, for it operated on tissues beyond those with which it came in contact. Hot vinegar had the advantages of hot water, and also of its own specific gravity.

Dr. Barker calleed attention to the slow action of hot water in some cases where the prompt arrest of hemorrhage was absolutely demanded, and to the delay often met with in obtaining it.

Dr. Byford concurred in the views expressed by Dr. Smith.

Dr. Smith was gratified at the preponderance of experience of the satisfactory action of hot water. In cases where death was impending, he thought it essential to elevate the hips, so as to carry more blood to the brain, and thus give the stypic an opportunity to act. No therapeutic measure would invariably operate to our satisfaction. He thought hot water and a Davidson's syringe were reasonably apt to be at hand under the circumstances to which his paper referred.

SOME POINTS CONNECTED WITH THE SUBJECT OF DYSMENORRHŒA

was the title of a paper by Dr. C. D. Palmer, of Cincinnati, in which the mechanical theory was characterized as plausible and natural, and was stated to have received a great impetus from the writings of Sir J.

Y. Simpson and Dr. Marion Sims. The theory had continued to be questioned, however, and, although generally still accepted, and, although doubtless applicable in a certain number of cases, it was questionable if it could count for much in the general etiology of dysmenorrhœa. The plausibility of the theory was strengthened by the temporary benefit so commonly produced by dilatation and other operative procedures calculated to relieve stenosis. There were several reasons why, the speaker thought, the theory should not be held to cover the general run of cases —chiefly included in the proposition that the pain was not proportionate in intensity to the amount of obstruction present, and that the most intense pain was often present without any obstruction whatever, while in cases of marked narrowing or sharp flexure of the uterine canal there was frequently not the slightest pain. On the whole, the obstruction theory could not be regarded as established. In many cases there was a state of the endometrium that might be called neuralgic—a condition that made it exceedingly sensitive on the passage of a sound, and that was aggravated by the congestion incident to menstruation, also by the contact of clots, etc. In a flexed uterus, hampered by the mere fact of the deformity, the tissue of the organ could not yield and swell during the menstrual congestion as it ought to do, so that the pain was the result of compression. In general, the affection was a neurosis, due to defects of the system at large, which latter might be an error of nutrition or an altered action of the nervous system.

In regard to treatment, in young women local measures should be omitted, at least at first. It was improper to regard every case of dysmenorrhœa as calling for such treatment. To correct derangements of the system was our first duty. Local treatment might prove to be needed in the end. Iron would do much good in cases of scanty flow, and arsenic where the flow was profuse or too frequent. Electricity was uncertain in its effects. Sometimes corrosive sublimate and iodide of potassium, in small doses, continued for months, the author had often found useful. The same was true of moderate doses of tincture of cimicifuga racemosa and tincture of pulsatilla during the periods. Opiates were to be given only with the greatest caution, and only where absolutely required. Dilatation of the uterine canal should not be resorted to until medication had failed; and this measure did not really operate by dilatation, but partly by blunting the sensibility, and partly by rupturing circular muscular fibers. It was best done with graduated bougies, or with two-bladed dilators. Incision of cervix, the author thought, had been much overrated, and resorted to far too often. Its field has now, with the lapse of time, been considerably limited.

Dr. Chadwick was very much of Dr. Palmer's way of thinking on the subject, and for some years past he had been gradually giving

up the operation of incision, now limiting the latter to cases of marked stenosis of the os externum. The pain of dysmenorrhœa, in obstructive cases, was, he thought, generally due to spasmodic contraction of the uterus or of the Fallopian tubes, analogous to the rectal and vesical tenesmus caused by fissure of the anus or prostatic obstruction, and reflex in its mechanism. He had treated several patients satisfactorily by inducing slight bromism before the flow and by giving coca and carbonate of ammonium during the flow.

Dr. Barker thought Dr. Palmer had expressed, better than had been expressed before, views with which in the main he was thoroughly in accord. Mechanical obstruction, he believed, was but rarely the real cause of dysmenorrhœa, but he supposed it was sometimes. It was very important to distinguish between uterine and ovarian dysmenorrhœa. In cases where the pain lasted only up to the beginning of the flow, he believed the pain was due to the effort of the uterus to relieve its own congestion by the occurrence of hemorrhage. This form of the disease was met with both in plethoric and in anæmic women. Of ferruginous preparations, he preferred the lactate, from its being the most readily assimilable—three to five grains three times a day, with chlorate of potassium. Where the uterus was really at fault, he had had more satisfaction from the use of apiol than from any other remedy—two or three capsules, after each meal, beginning two days before the flow.

In cases where the pain did not begin until the flow had continued two or three days, there was excess of ovarian excitement. In such cases the bromides were very efficient, especially the bromide of sodium, ten to fifteen grains three times a day (at the middle of the forenoon, the middle of the afternoon, and bedtime), beginning several days before the flow.

SECOND DAY—MORNING SESSION.

The meeting was called to order at 10.20 a.m., by the President, who proceeded to deliver the annual address.

In addition to the Fellows present at the first day's session, the following-named gentlemen were in attendance: Dr. W. H. Baker, of Boston; Dr. Samuel C. Busey, of Washington; Dr. Charles Carroll Lee and Dr. Henry J. Garrigues, of New York.

THE PRESIDENT'S ADDRESS; A BIOGRAPHICAL SKETCH OF DR. NATHAN SMITH, FOUNDER OF THE DARTMOUTH MEDICAL COLLEGE.

The address alluded to the early history of ovariotomy, Dr. Nathan Smith having been the second to perform the operation, doing it independently of any knowledge of what had been done by Dr. Ephraim McDowell. The President then traced the early career of Dr. Nathan Smith, followed by a history of his arduous work as a teacher of medicine and of his remarkable achievements as an organizer of medical colleges.

The address closed with the prediction that a monument would yet be set up in New Hampshire recounting the deeds of Dr. Nathan Smith.

Dr. Samuel D. Gross, of Philadelphia, present by invitation, was not aware that Dr. Smith had not known of Dr. McDowell's ovariotomy at at the time of his first operation. He added that Dr. Nathan Smith's greatest achievement had not been spoken of—that of begetting such a son as Dr. Nathan R. Smith, of Baltimore.

A Rare Form of Abdominal Tumor.—Three Cases.

Dr. Thaddeus A. Reamy, of Cincinnati, read a paper recounting three cases of hæmatoma of the abdomen, and showed a specimen from one of these cases. In one of the cases there was a sarcomatous growth. In the two other cases puncture was followed by recovery.

Dr. Charles Carroll Lee, of New York, concurred with Dr. Reamy as to the extreme rarity of cysts of the omentum.

Dr. Sutton thought that as a rule a sarcoma of the omentum could not be distinguished from a carcinoma of the same structure, except by opening the abdomen, although perhaps by the method of exclusion the situation of a growth might be ascertained with reasonable probability to be in the omentum. Given a fluctuating tumor thought to be situated in the omentum, he regarded it as dangerous to puncture it with a trocar or with an aspirator needle. In all such cases exploratory laparotomy should be performed.

Dr. Campbell thought that tapping sometimes had to be done in such cases as a palliative measure, under circumstances where laparotomy was not to be thought of.

Dr. Reamy argued in support of the practice of puncturing cysts under these circumstances, considering it free from certain dangers attaching to a like method of dealing with ovarian cysts; and, in fact, the two patients he had tapped had both recovered.

A paper, by Dr. Edward W. Jenks, of Chicago, on "A New Method of Operating for Fistula in Ano" was read by title, the author being absent.

Congenital Fissure of the Female Urethra, with Extrophy of the Bladder.

Dr. Campbell read a paper embodying an account of a case of this sort, in which, he thought, a plastic operation would be advisable at the time of puberty, the patient being now a young child.

Dr. B. B. Browne, of Baltimore, related a case somewhat similar.

Dr. Mann related a case of laceration of the perinæum in a young child, in which he advised the operation at the time. It was done without difficulty, and the result was perfect. Arguing by analogy, he thought the operation had better be done early, so as to favor a more natural growth of the parts.

Dr. Campbell thought that, in a case as he had related, the scarcity of

tissue was so great as to interfere, with the performance of a plastic operation.

A Study of the Ætiology of Perineal Laceration, with a New Method for its Proper Repair.

Dr. Thomas Addis Emmet, of New York, read a paper with this title, a notable feature of which was an expression of the author's belief that in ordinary cases of laceration of the perineum no symptoms were produced by the injury, after it had once healed, except those of a reflex nature. In many cases of complete rupture, the pelvic organs would still be found in their normal situation. Moreover, the ordinary forms of operation for closing perineal laceration rarely, if ever, overcame the symptoms for which they were undertaken. The explanation was, that it was not a solution of continuity affecting the muscular structure of the perineum that constituted the source of symptoms, nor the restoration of that structure that would accomplish the cure of such symptoms; it was the concomitant injury of the fascial structures of the pelvis that was of consequence, and it was to the repair of those tissues that our attention should be directed. Frequently the pelvic fascia was overstretched in difficult labor, especially if the perneum was "supported." In the operation for restoring the perineum, it was useless to carry the denudasion so far externally as was often done. It should be limited to the true ostium vaginæ, and the perineum should be further strengthened by bringing forward a transverse fold of the posterior wall of the vagina, even if there was no proctocele. The mistake should be avoided, however, of taking up too much of the posterior wall, for that would give rise to an amount of tension that would make it necessary to remove the sutures to prevent their cutting out. The author had used perforated shot with sutures of silk-worm gut, and had been pleased with the efficiency of this device. During the past year all his operations had been done by the method described. (Here, by request, Dr. Emmet drew diagrams on the blackboard illustrating his operation, and the consideration of his paper took the form of questions and answers tending to explain the steps in the operation and their purpose. The features of the operation were, in brief, as follows: Two transverse crescentic spaces were to be denuded—an outer crescent with the concavity looking backward, and an inner crescent with the concavity looking forward. To establish the situation of these crescents, three tenacula were to be employed. With two of these instruments the open mouth of the vagina was to be brought together by inserting the points at the level of the upper limit of the remains of the hymen, one on each side. The points thus seized would mark the extremities of the anterior crescent, and while they were held together with the instruments the third tenaculum was to be inserted in the posterior vaginal wall, in the median line, at a point that could be drawn forward to meet the two former without giving rise to undue ten-

sion. This point would mark the center of the posterior crescent. The denudation having been effected, the two crescentic denuded patches were to be stitched together. This would have the effect of drawing the the perineal tissues upward, so that the vertical rent in the median line would be much shortened, and could now be closed with a few sutures. The latter step, however, was not essential).

AFTERNOON SESSION.

CONTINUATION OF THE DISCUSSION ON DR. EMMET'S PAPER.

Dr. Emmet gave a brief *résumé* of the paper, emphasizing his disbelief in the doctrine of a substantial perineal body as a supporting body. His operation was a simplification, enabling operators to effect repair who might be incapable of doing so by the ordinary operations.

Dr. Reamy could not avoid the conclusion that the operation could not well be substituted in general for the operatien Dr. Emmet had previously inculcated. He doubted if there would ever be such shrinkage of the undenuded area between the two crescents as to do away with the danger of rupture occurring again at a subsequent confinement; and he doubted if the operation could do more than get rid of redundant tissue in the posterior vaginal wall.

Dr. Frank P. Foster, of New York, expressed himself as even more radical in the view that the perineum had physiologically no such office to perform as to sustain the parts above it, and therefore its restoration was not demanded as a means of support. In abnormal conditions of the parts situated above it, it might and often did supplement their defects. Moreover, it had certain functions, not pertinent to this discussion, which called for its repair.

Dr. Sutton dissented from Dr. Emmet's view as to the non-necessity of repairing lacerations of the perineum apart from injury to other structures, and appealed to common observation of the ills with which women with rupture of the perineum suffered, and which were commonly cured by closing the laceration. He traced a similarity between Dr. Emmet's new operation and the one practiced by Hegar.

Dr. Emmet again denied the supporting office of the so-called perineal body. He thought his paper had not been very clearly understood. In reality, he was not much at variance with the other speakers, as would be seen when the paper was read carefully.

THE MANAGEMENT OF ACCIDENTAL PUNCTURE AND OTHER INJURIES OF THE GRAVID UTERUS AS A COMPLICATION OF LAPAROTOMY.

Dr. Lee read a paper with this title, in which he expressed his belief that, in addition to the few cases on record, many more must have occurred. He then epitomized the scanty statistics of the subject—seven cases, including one, already reported, in his own practice. He dis-

sented from Sir Spencer Well's advice to remove the uterus under such circumstances, and expressed his views in the following conclusions: 1. The pregnant womb may be punctured or otherwise wounded during laparotomy without necessarily causing abortion. 2. Miscarriage seems, both *a priori* and from clinical evidence, to depend upon injury of the uterine contents, not of the womb itself, however severe. 3. If the former has certainly occurred, Cæsarean section is indicated, and should be performed promptly. In this case the utmost care must be taken subsequently to secure thorough drainage from the uterine cavity. 4. If the uterine walls alone are injured, the wound is to be treated on general principles. If there is a deep puncture or incision, it must be sutured with the minutest care, with exact coaptation of the edges. For this purpose fine silk sutures, rendered antiseptic, are the best. If there is a nick or superficial puncture, it must not be ligated, for ligatures cut through uterine tissue quickly. If the wound is too small to require sutures, the bleeding points must be touched lightly with Paquelin's cautery until oozing has ceased. Good surgery and the dictates of humanity alike demand that, under such circumstances, a chance of survival should be given the child as well as the mother.

Dr. H. P. C. Wilson had had some experience of the sort alluded to by Dr. Lee. In a case of pregnancy of four month's duration he had performed ovariotomy, and found a firm pedicle attached to the uterus. On dividing it there was considerable oozing from the uterine tissue, which had been encroached upon slightly by the scissors. It was checked with Monsel's solution, and the patient did well, but, three or four weeks afterward, intense pains set in and lasted for about ten days, when an abscess broke and abortion took place. He did not doubt that the abortion was due to the abscess.

Dr. Henry J. Garrigues, of New York, had had the good fortune to witness Dr. Lee's operation, and it had been his impression at the time that the trocar did not open the amniotic sac.

Dr. Wm. H. Byford, of Chicago, thought the profession indebted to Dr. Lee for the paper he had read. He called attention to the fact that it was only in Dr. Lee's own case that pregnancy was suspected beforehand. He himself had had a case, in which also he had failed to make out the existence of pregnancy by omitting to examine for it. He thought that Dr. Lee's rule as to stitching up the wound where the ovum was not injured should not be made absolute, for in his case, one of advanced pregnancy, the tractile action of the muscular tissue converted the puncture at once into a gaping orifice, and in such a case sutures would not hold. He thought that under such circumstances, even if the ovum was not injured, the uterus should be emptied and the wound stitched up. In early pregnancy, however, he would follow Dr. Lee's rule.

Dr. Lee would in general avoid the use of Monsel's solution. He

thought there was great force in the distinction brought forward by Dr. Byford.

Is Extirpation of the Cancerous Uterus a Justifiable Operation?

Dr. A. Reeves Jackson, of Chicago, read a paper on the above title. Starting with the general postulate that the use of a remedial measure that usually failed to accomplish its object was not kept up by honest and humane men, especially when its employment involved manifest danger to life, and deducing, from a review of the history of hysterectomy for cancer, that this operation very commonly proved the direct cause of speedy death, and that in other cases it scarcely did more for the patient than to render her last days somewhat more comfortable than they would otherwise have been, Dr. Jackson reached the conclusion that the operation was unjustifiable, whether done by the vaginal or by the abdominal method. The operation was incapable of such improvement as to make it anything else than too difficult and dangerous to be countenanced. Even when it did not destroy life, it might sometimes, by being really a partial procedure, stimulate and hasten the extension of the disease. The paper closed with a telling indictment of so called "brilliant" surgery —operations that killed being termed brilliant.

Dr. Van de Warker placed great reliance on the use of caustics, instead of operative measures, and he employed a saturated solution of chloride of zinc. He showed specimens of large sloughs cast off after the action of the caustic.

Dr. Emmet coincided fully with the views expressed in the paper. His experience had been limited to one case, which had terminated unfavorably. In that case he had operated against his own conviction, as the operation was one he had always opposed. (This case will be found reported in the proceedings of the New York Obstetrical Society.) If the operation was to be done at all, it should be done by the vaginal method.

Dr. Wm. H. Baker, of Boston, could not believe that operative measures were wholly useless, for in a number of instances he had operated for the removal of portions of the uterus for cancer, with the result of prolonging life for years. He described and figured his own method of operating, being a combination of Sims's and Schröder's operations. Dissecting the cervix loose from its attachments up to the level of the os internum, a cone-shaped piece was then removed, the apex reaching nearly or quite to the fundus. He had done this operation in thirty cases, and without a single death. Extirpation of the entire uterus, however, was advisable in extremely few cases, and those were mostly cases in which the disease began in the body of the organ, the cancer being of the glandular form, and both body and cervix were involved. He had never seen just such a case.

Dr. Palmer thought that the best that could be said for hysterectomy was that it might possibly be justifiable in a few instances, those, namely, of sarcoma starting in the body of the uterus.

Dr. Sutton had operated in five cases, in all by Simon's method. He thought the abdominal method should never be adopted in cases in which it was possible to perform the vaginal operation.

Dr. Jackson was not surprised to hear of the good results that had followed less dangerous operations in Dr. Baker's hands, and he doubted if either Dr. Baker or Dr. Sutton would ever meet with a case in which he would advise extirpation of the uterus.

THIRD DAY—MORNING SESSION.

Election of Officers.—The following officers were elected for the ensuing year; President, Albert H. Smith, M.D., of Philadelphia; Vice-Presidents, James R. Chadwick, M.D., of Boston; Samuel C. Busey, M.D., of Washington; Secretary, Frank P. Foster, M.D., of New York; Treasurer, Matthew D. Mann, M.D., of Buffalo; Other Members of the Council, T. Gaillard Thomas, M.D., Fordyce Barker, M.D., of New York; Thaddeus A. Reamy, M.D., of Cincinnati; R. Stansbury Sutton, M.D., of Pittsburg; For Active Fellowship, R. B. Maury, M.D., of Memphis.

In addition to those present at the preceding sessions, the following named Fellows were in attendance: Dr. T. Gaillard Thomas, of New York; Dr. James V. Ingham, of Philadelphia; and Dr. George J. Engelmann, of St. Louis.

MENSTRUATION AFTER EXTIRPATION OF THE OVARIES.

Dr. Henry F. Campbell had prepared a paper with this title, of which he gave a brief oral summary. While conceding the preponderating influence of the ovaries in the menstrual function, he was inclined to think that there was a nervous mechanism, probably centering in the lumbar enlargement of the spinal cord, by the action of which, quite apart from "habit," periodical hæmorrhages from the uterus might be brought about that were wholly indistinguishable from ordinary menstruation. The speaker traced interesting analogies from the effects of forced lactation in re-establishing the menstrual function and in overcoming sterility.

Dr. William Goodell, of Philadelphia, had found menstruation after removal of the ovaries very uncommon, but was quite ready to coincide with Dr. Campbell as to its cause when it did take place, the irritation being that caused by the ligature. In saying that menstruation was uncommon under such circumstances, of course he did not include the false menstruation that always, according to his experience, took place within a few days after the operation. When menstruation did return, it was owing, he thought, to the fact that some ovarian structure was left behind, and, on account of the occasional difficulty of removing all

ovarian tissue by the vaginal method of oöphorectomy, he had given up that method of operating.

Dr. Thomas Addis Emmet, of New York, related a case of his own, in which menstruation had continued after complete removal of the ovaries.

Dr. Henry J. Garrigues, of New York, referred to the occasional existence of a supplementary ovary.

Dr. T. Gaillard Thomas, of New York, thought the connection of the ovarian function with menstruation could not be regarded as yet accurately and minutely defined. In regard to Dr. Campbell's theory, he had no data. His impression was that menstruation after removal of the ovaries was exceptional. When it did take place, it was not true menstruation, but a metrostaxis, due to the habit of the uterus, and was not continued for a great length of time. He had found the same results, in this respect, after Tait's operation as after Battey's. He related a case of supplementary ovary in a patient from whom he had removed the two other ovaries early in the summer, and concerning whose menstrual function subsequently he knew nothing. He was decidedly inclined to adhere to the old theory of ovulation as the cause of menstruation.

Dr. William H. Byford, of Chicago, thought our positive data bearing upon this question were very insufficient to serve the purpose of its elucidation. He agreed with what Dr. Thomas had put forward as to the facts generally observed, and also as to the ovulation theory. He had had only one instance of continued periodical hæmorrhages from the uterus after removal of both avaries, and in that case there was not the strict periodicity of true menstruation.

Dr. Matthew D. Mann, of Buffalo, had always held the views expressed by Dr. Thomas and Dr. Byford, but his experience in the class of cases under discussion had led him to attribute the flow to some diseased condition of the uterus. In one case, what seemed to be true menstruation persisted after true removal of both ovaries, together with the whole body of the uterus, and was found to be due to the development of cancer of the cervix. He thought that reports of cases should not be accepted unless a thorough examination had been made to discover the cause of the loss of blood.

Dr. Campbell knew that the discharge was not always due to portions of ovarian tissue being left behind, but, of course, there might be a third ovary, although he had never seen one.

AFTERNOON SESSION.

Remarks on Chronic Abscess of the Pelvis.

Dr. Byford read a paper, largely based on clinical data, in which he depicted the serious consequences that often took place from extensive chronic abscesses within the pelvis in women, and detailed the methods

he had found most succesful in their treatment. A notable point made was the satisfactory results that he had met with from thorough removal of the layer of flabby, ill-conditioned granulations that often lined the cavity of the abscess—tissue that it was extremely difficult to make take on a real reparative action. He had found that by removing it with a curette most gratifying results had been accomplished in several instances.

Dr. Thomas thought there was much original research displayed in the paper. Such abscesses should always be sought for, but, when they were situated high in the pelvis, it was not generally advisable to attempt to give vent to their contents by puncture unless there was very positive evidence as to the precise situation of the accumulation. The aspirator was a very bad means of treatment, and he had made use of it only as a means of diagnosis. He preferred an exploring needle, followed by a small bistoury sliding in the groove of the needle. His practice was now to keep the opening from closing by inserting a small glass tube with a flange. The cavity was then stuffed with iodoformed tow, which was changed daily, and iodized-phenol injections were employed. In many cases he had found it necessary to open pelvic abscesses above the brim of the pelvis.

Dr. Goodell was much struck with Dr. Byford's suggestion to use the curette in the cavity of the abscess, and thought it likely to be very serviceable. Where there was an opening above the brim, he passed a sound, made a counter-opening on its point through the vagina, and inserted a drainage-tube. Antiseptic injections were to be used; but he had found it necessary to be cautious in the use of carbolic acid for this purpose. Occasionally he had used the aspirator, but did not regard it with much favor. In one instance a furious inflammation had followed its use. He had resorted to the supra-pelvic incision in some instances.

Dr. R. Stansbury Sutton, of Pittsburg, Pa., had seen Esmarch scrape out abscesses with curettes.

Dr. Campbell endeavored to encourage rather than repress granulations, and relied a good deal on the use of tartrate of iron and potassium to prevent the formation of flabby granulations, using it in the form of injections.

Dr. Byford admitted the danger of lighting up acute inflammation by exploratory procedures, and would inculcate caution in selecting for them only cases in which the abscess was chronic, and accompanied with well-marked fibrinous exudation. He, too, had opened chronic abscesses above the pelvis, but regarded it as a resource to be confined to desperate cases.

ERGOT: THE USE AND ABUSE OF THIS DANGEROUS DRUG.

Dr. George J. Engelmann, of St. Louis, read a paper in which he gave his experience in cases to which he had been called in consultation, and

had had occasion to observe the evil effects of the administration of ergot by those previously in charge. The use of this drug he declared to be very widespread in his part of the country, and he felt that the harm it caused was so common that it would be well to banish it from obstetric practice altogether.

Dr. Joseph Taber Johnson, of Washington, referred to a paper he had read before the society last year, in which he had called attention to the point that Dr. Engelmann had enumerated. He now wished to defend the profession from the sweeping charge that they always used ergot in labor.

Dr. Campbell almost always gave ergot in childbirth, but seldom before the birth of the child, and never before the full dilatation of the os uteri.

Dr. Albert H. Smith, of Philadelphia, thought the use of ergot in midwifery an unmitigated evil. There was always danger of its doing harm, and it never did good.

Dr. Ellwood Wilson, of Philadelphia, was astonished to hear Dr. Engelmann say that ergot ought to be banished from use in midwifery. He always used it in cases of placenta prævia, and for the very purpose of causing tetanic contraction of the uterus. He always used it, too, in post-partum hæmorrhage. For this accident, it was usually given too late and in too large amount. In cases of abortion, also, he always employed ergot, and had never met with any bad results.

Dr. Engelmann referred again to some experiences of his own that had led him to entertain the decided views he had expressed in the paper.

A Theory to Explain the Relaxation of the Vagina and Perineum During Labor.

This paper, by Dr. James R. Chadwick, of Boston, was read by title, the author having been obliged to return home before it was reached.

The eighth annual meeting was then declared adjourned. The next meeting will be held in Chicago, on Tuesday, Wednesday, and Thursday, September 23, 24, and 25, 1884.

Feeding Syphilitic Infants.—At l'Hopital des Enfants Assistés in Paris, where many of the waifs and foundlings of the city are cared for, a unique feature has been introduced by M. Parrot, containing a nursing service for syphilitic infants. The nurslings draw their nourishment directly from the teats of the ass, to which they are presented five times during the day, and three times at night. They thrive under this treatment, and seventy per cent. live, while almost all formerly died when fed from the bottle (*Boston Medical Journal*). After all, why should they not thrive? Would they not have been nursing asses' milk if they had been imbibing from the maternal mamma?

Abstracts and Selections.

I.—OBSTETRIC.

The Use and Abuse of Ergot.—An essay by George L. Woods, M.D., of Springfield, Mass., published in the *Boston Medical and Surgical Journal.*

The object of this paper is to invite attention to the action and therapeutic indications of ergot of rye, more especially in obstetric practice, with some incidental observations upon its possible dangers on the one hand, and its latent resources on the other. Although the use of oxytocics has existed from very remote times, the list of drugs which possess this property in a special degree is very short.

It has been ascribed in varying degrees to borax, cinnamon, tansy, cottonroot bark, cannabis indica, etc., but the leading member of this class which has attained such importance and universal use is undoubtly ergot of rye, and this very fact, to the mind of the writer, justifies and calls for our constant study of this powerful agent until we better understand its capacity and resources.

The natural history and general characteristics of spurred rye, and the numerous but unsatisfactory attempts to isolate its active principle which have been made, are familiar to us all, and need not detain us. The phenomena of chronic poisoning, which Trousseau so graphically describes as seen among the peasantry of France, who largely consume ergoted rye as food, we do not see. The symptoms of acute poisoning, which also we seldom see, are, briefly, dilatation of pupils, dimness of vision, frontal headache, giddiness, stupor, collapse, and sometimes partial paraplegia. Dr. E. R. Squibb considers an underfed and semi-scorbutic habit of body essential to the development of poisonous symptoms from the ingestion or administration of ergot.

The presence of ergot in rye flour may be demonstrated in the following manner: Mix a small quantity of the sample with ether, add a few cystals of oxalic acid, boil, and allow the liquid to clear. A red tinge indicates the presence of ergot.

When our countryman, Dr. Stearns, first called attention, in 1807, to the scientific use of ergot as a uterine motor stimulant, its physiological action was but imperfectly understood, and even now eminent authorities can scarcely agree upon more than the one incontrovertible fact, that ergot increases the force and frequency of the contractions of the uterus with a tendency to make them tetanic in character. That it has a similar contractile effect upon unstriped muscular fibre, which is so generally distributed in the hollow muscular organs, seems equally clear.

Wernich attributes the ecbolic properties of ergot to irritation of the

uterine nervous centres, caused by secondary arterial anæmia of the spinal cord, due to loss of tone in, and dilatation of, the veins.

Kohler refers the contractions to increased irritability of the peripheral nerves in conjunction with spinal anæmia.

A committee on therapeutics in the Chicago Society of Physicians and Surgeons recently reported that ergot excites activity of cardiac inhibitory centres, and also the vaso-motor nervous centre in the medulla, thereby slowing the heart's action, causing contraction of the arterioles, increase of blood pressure, diminution of blood supply, and predisposing to death of the extremities. Very large doses then would seem to have a paralyzing effect upon the heart.

A knowledge of the physiological action of drugs is generally essential to their judicious administration. The most prominent action and use of a drug should not engage our attention to the exclusion of other occasional but deplorable effects. We should remember that quinine is not only our closest approximation to a specific in ague, but that in certain cases and conditions it works an irreparable injury to the organ of hearing, and that an ecbolic effect upon the gravid uterus has been directly caused by its careless and routine exhibition. So in the use of ergot, every consideration of professional honor, success in practice, and safety of our patients, requires of us an abiding consciousness that we are using a double-edged sword, potent not only to stimulate a flagging uterus, but equally capable in careless hands of destroying valuable life, and mortally wounding a professional reputation. But however interesting and instructive it might be to know precisely how the nervous, circulatory, and muscular systems are influenced by ergot enough may now be learned by the obstetrician to insure its safe employment.

When we reflect upon the extensive, indiscriminate, and unscientific use of this potent agent by ignorant empirics long before recognition by the profession, we may well question whether more harm than good did not result. Seventy-five years ago, when it was first introduced, medical science was embryoic as compared with its grand proportions of to-day; the investigation of new remedies was not then a daily occurrence. The drug had to wait long years before its constituents were demonstrated by analysis and it became established in popular favor. The earlier writers give meagre and careless directions for its use, (1) and discredit the occasional reports of its deleterious influence upon the fœtus which were made thus early. However presumptuous it may appear to criticize the medical teaching of the past fifty years, a certain independence of thought and action is justifiable. It is thus that our science progresses. In proportion as we break away from the traditional and plunge into the experimental do we confirm and establish existing theories or discard and supplant them with those which are new and progressive. Because our

1 Eberle, Mat. Med., 1825.

text-books have always taught that with certain precautions ergot is innocuous in tardy labor we are not obliged to accept the statement as a fact if it can be shown at present or in future that its use has not been sufficiently restricted. That such has been and even now is the case is the firm conviction of the writer.

The use of ergot in the first stage of labor is not to be mentioned in this presence.

In view of the instruction which the average graduate has received, and the fact that he enters upon the practice of obstetrics without having seen a case of labor, but with an indefinite idea that ergot is a harmless time and labor-saving drug, its employment in the second stage of labor becomes a radically different matter. Abundant authority for this use, however, is attested. The indications usually given, which present such a remarkably stereotyped appearance in every succeeding work on obstetrics as to preclude in the mind of the student the possibility of any other views being entertained, may be tersely stated as follows: In lingering labor from uterine inertia it is regarded as essential that the presentation be vertex, the cervix well dilated, the perinæum and ostium vaginæ relaxed, and that there be no fœtal or pelvic deformity or other obstruction to the speedy delivery of the child. The contra-indications as given naturally suggest themselves, but it is the main object of this paper to express the belief of the writer, who never gives ergot at this stage of labor, but uses the forceps instead, that our authorities have been too liberal in their indications; that the contra-indications and dangers have not been fully appreciated or enumerated with sufficient fullness and clearness; that the routine administration of ergot, into which some of us fall, has been productive of great harm; and, finally, to urge its greatly restricted use.

As employed by intelligent physicians to-day rupture of the uterus is doubtless a remote danger to the mother, but if we only had access to Clay's Hand-Book of Obstetric Surgery, and gave ergot when the os uteri became dilated to about the size of half a crown, as therin directed, the prospect of a lacerated cervix would be exceptionally good. The approximately uninterrupted pressure of the head upon an incompletely dilated os is well calculated to bring about this untoward result. Clay is evidently prejudiced in favor of ergot, for he allows its moderate use in primipara, and bids for distinction in connection with its introduction to British obstetric practice.

Rupture of the perineum is an accident, irrespective of the use of ergot, which is occasionally unavoidable. The wonderful power of the uterine contractions under the influence of ergot is best appreciated by those whose hands have been subjected to the pressure. In proportion as ergot is used does the distention of the perineum become unmanageable, and the liability to its serious injury increase. Too little attention

is paid to the fact that in lingering labor the maternal passages are hot and dry, and unprepared for the rapid and forcible expulsion of the child. More or fewer abrasions of the mucous lining cannot fail to occur, over which the lochia must flow, and through which septic matter may be absorbed into the circulation of the mother, and prejudice her chances of recovery, while lacerations of the cervix generally escape detection until long afterwards, when their ultimate effects have impelled her to consult her physician.

The writer feels that he cannot too strongly urge the importance of withholding ergot during the entire period of dilatation and subsequent expulsion of the child. Exceptions will be taken to this total prohibition by men of experience who claim immunity from accident. Granting that these claims are sometimes well founded, the facts yet remain that ergot is daily given before the cervix is fully dilated; that rigidity and laceration often follow the sudden and continuous impingement of the head upon it; that the drug is often and repeatedly given to save time or through deference to the wishes of the patient, and before any disproportion of diameters can be accurately ascertained. The gauntlet of impaction, the forcible passage of a large head through a small pelvis, pelvic phlegmasiæ, sloughing, septic absorption, etc., must inevitably be run.

In view of this and more which might be pointed out did time serve, we are confronted by this question, Do the benefits arising fron this use of ergot compensate for the risks incurred? But little notice has yet been taken of idiosyncrasy. In one case the writer has seen the ordinary symptoms of collapse follow the use of a moderate dose of ergot before delivery of the placenta, accompanied by a tonic contraction at the neck of the uterus, which effectually prevented its accomplishment for several hours. Within a few years several similar cases have been reported in the journals, but whether this is an important factor in the production of the deplorable results sometimes following the exhibition of ergot requires further demonstration.

Considering the action of ergot upon the circulatory system, an enfeebled or diseased heart would appear to be a contra-indication to its use which is universally ignored. Cazeaux emphasizes the dangers to the mother, while Schrœder argues that the persistent contraction of the uterus induced does not materially aid the dilatation of the soft parts, and disputes its efficacy as as an expulsive agent. Barnes bears testimony to the unreliability of ergot, and its tendency to add to the already existing depression of the patient. Men of large observation and experience assert that ergot is treacherous if used to prevent impending hemorrhage, and that the exhausted condition of the uterus which succeeds such violent contractions sometimes predisposes to the emergency feared. Meigs does not give ergot for its expulsive effects, but prefers the for-

ceps. Though abuse may grow out of the use of the forceps as well as of ergot their employment presents marked advantages over the latter. A case which is suitable for ergot admits of their application; the liability to lacerations is materially lessened; the progress of the child is under control; the risk of asphyxia is obviated, and its safety is assured.

The danger to the child under the use of ergot can no longer be underestimated. Whether a poisonous effect is produced, as has been claimed, cannot yet be definitely stated, but the tendency to tetanic contractions with prolonged pressure upon the placenta or funis seriously interferes with the oxidation and decarbonization of the fœtal blood, and imperils the life of the child. If Churchill (1) be followed, who allows ergot to be given when the breach presents, how can this danger fail to be materially increased when the placenta is firmly compressed between the unyielding head and the uterine wall?

Spiegelberg insists upon the necessity of carefully observing the fœtal heart after the use of ergot, in order that the forceps may be immediately resorted to in threatened asphyxia. That this is often done may well be doubted. Benicke reports twenty-seven cases in which ergot was given during the second stage on account of uterine inertia. Spontaneous delivery occurred in but seven of these cases. It should be axiomatic with every practitioner that economy of his own time never justifies the use of ergot, but beyond every private and selfish consideration he cannot escape the responsibility imposed by a knowledge of its unreliability, its manifold dangers, and the frequent necessity for instrumental interference.

The routine practice of many physicians of giving a drachm of ergot as soon as the head is born is also open to objection. It sometimes locks up the placenta so tightly that only time, chloroform, or nitrite of amyl will release it. Personal observation leads the writer to this conclusion, although practitioners of much larger experience doubt its possibility, asserting that it never has occurred to them. This contingency, however, has long been recognized. An author, writing so long ago as 1835, says: "An overdose of ergot may produce such contractions of the uterus after delivery as to cause retention of placenta." To show that this is not an antiquated thing which has long been exploded, we may quote from so recent an author as Lusk, who takes advanced ground and represents a growing sentiment against the routine and indiscriminate use of this agent.

After prohibiting its use in the second stage of labor, except as a prophylactic against post-partum hemorrhage, he says: "The only imperative use of ergot is in post-partum hemorrhage, resulting from uterine atony; but even then it should be withheld until after the expulsion of

1 System of Midwifery.

the placenta, lest the uniform uterine contractions lead to its prolonged retention or interfere with manual efforts for its extraction."

Because of this peculiarity in the action of ergot it cannot be relied upon in the management of abortions and miscarriages. It is after the uterus has been completely emptied of its contents, and for a varying degree of time after delivery, then, that ergot, in the opinion of the writer, meets its proper and strongest indication. No physician should attend a case of labor without having ready to hand hot water and a solution of ergotine, with appropriate syringes prepared for instant use, should hemorrhage occur after complete evacuation of the uterus. Post-partum hemorrhage is thus robbed of half its terrors.

One of the most frequent indications for the use of ergot is subinvolution of the uterus. It has long seemed to the writer that appropriate prophylactic treatment, provided it could be applied, would greatly reduce the number of these cases. This treatment which is found to be impractable without the hearty coöperation of the patient, should begin from the moment the third stage of labor is completed. At this time, when the uterus has thrown off the burden which it has carried for nine months, the organ weighs according to Heschl, from twenty-two to twenty-four ounces; and its length, according to Bœmer, who has measured in sixty-four cases, averages a little more than six inches. Hewitt gives the length as eight inches. At the end of the first week, at which time women often get up, the uterus weighs from nineteen to twenty-one ounces; at the end of the second week, from ten to eleven ounces; at the end of the third week, from five to seven ounces, and the nearest possible approach to the normal weight of about two ounces is not reached until the close of the second month. The new mucous lining of the organ does not form before the third week. We must dissent, then, from the views of an eminent writer, if, as reported, he advocates the encouragement of the patient, to rise and dress on the third or fourth day after delivery in ordinary cases. The writer ventures the opinion that this time for keeping the bed or lounge is much too short. Indeed, the time-honored period of nine days does not seem long enough. At this time, even, although the bulk of the uterus is considerably reduced, we have seen that it yet remains enlarged, soft, congested, and too heavy for its relaxed supports. Walking, standing, lifting, pelvic inflammations, etc., contribute to retard the process of involution, in many cases entirely arresting it short of completion, when we have resulting the condition of subinvolution, the grand predisposing cause of that long train of symptoms so familiar to the physician. Have we not here a clear indication for prophylaxis?

The patient should not only be kept longer in bed to facilitate involution, but we shall do well to remember that it is the soft, spongy, subinvoluted uterus for which Bartholow recommends ergot. Believing that

the process of involution is materially aided and advanced by the cautious use of ergot, it is the practice of the writer to give it in moderate doses for some days after delivery. Corroborate evidence of the value of this plan of treatment is not yet abundant, but Dr. Garrigues, of New York, may be quoted upon the use of ergot as follows: "Ergot ought never to be given during labor. I use this drug in every labor, but not until after the placenta has been expelled. I give it even for four or five days, because I think that by causing contraction of the muscular coat of the blood-vessels it counteracts absorption of septic matter, and by increasing uterine contraction insures good involution." The abuse of the use of ergot is by no means confined to the profession.

The late William Warren Greene once urged upon a class of students the propriety of using the simplest language with their patients, but recommended the invariable employment of scientific language among themselves. Some exceptions might reasonably be taken to the first injunction. We should all realize the wide-spread tendency to escape the dangers and responsibilities of maternity. Women are in constant temptation to seek means and use them privately to accomplish their object. Frequently we find them in the cities using ergot with the avowed intention of procuring an abortion. To all inquiries, from whatever source, concerning the nature and effects of ergot guarded answers should be given,—not necessarily false, but calculated to divert the mind from its ecbolic properties, and the botanical name only should invariably be given, as less likely to be remembered than the common one.

The unreliability of ergot has caused great annoyance. Camphor prevents much deterioration of the powder, but a fresh preparation is more reliable. The addition of one per cent. of acetic acid renders the liquid preparation permanent.

As it is sometimes desirable to give ergotine for several weeks in succession, it becomes not only an interesting but important as to how long the remedy can be given with safety. Doubtless no fixed rule can be laid down; but as some evidence can be advanced to show that ergotine has a cumulative effect upon the system, prudence would seem to dictate conservatism.

At a meeting of a medical society in Paris some time since Dr. Boissarie called attention to the possible dangers attending the prolonged administration of ergotine by the mouth. He detailed the case of a young woman of twenty-five, with albuminuria, who took a daily dose of two centigrammes of ergotine for four weeks. About a month after cessation of treatment gangrene developed in both inferior extremities.

Dujardin Beaumetz relates a case of enteric fever in which gangrene supervened after the exhibition of a daily dose of one gramme of ergot for one month. A case of pulmonary gangrene in a child of thirteen years has also been reported. Ergotine, in a daily dose of two centigrammes,

was given by the mouth for about two months for incontinence of urine. fatal hæmorrhage occurred within a month after cessation of treatment.

Dr. Lusk, of New York, reports a case of fibro-myoma of the uterus treated by ergotine injections into the subcutaneous tissue of the abdomen over the tumor. The bulk of the growth was rapidly reduced, but at the expense of gangrene of the compressed tumor and fatal septicæmia.

Antiseptic Midwifery.—This question is lately more prominently than usual to the fore, and its more enthusiastic advocates see in it the possibility of the eradication of puerperal fever from the nosological list. 'Tis a consummation devoutly to be wished. The grand essentials by way of prophylaxis of this dread complication of child-bed are the prevention of infection and auto-infection. These secured, puerperal fever would, doubtless, soon be a relic of other days. Antisepsis as a prophylactic measure, while it would be serviceable to both these essentials, would be chiefly so in the case of the former. Infection is carried by the hand or clothes of the accoucheur, by instruments or other intermediate means. A thorough means of antisepsis would of course be serviceable to the prevention of this. Corrosive sublimate, in solution of one part in from 2,000 to 3,000 has latterly been highly extolled in this connection, but the great difficulty of thorough disinfection has been demonstrated by the many lamentable instances of puerperal fever following in the wake of some particular physician, despite his most conscientious efforts at disinfection. Perhaps corrosive sublimate may prove to be the antiseptic for which we have been waiting in such cases.

To prevent auto-infection means the removal of shreds and clots, the prevention of the decomposition of those which the best directed efforts failed to remove, and the antagonizing in the system of the products of such decomposition, the absorption of which the best directed efforts may have failed to prevent. In the accomplishment of these ends the antiseptic treatment occupies a place of prime importance. We think, however, that the advocates of this treatment have overlooked in their enthusiasm, the feasibility at least, if not the importance, of preventing auto-infection by a complete removal of the source thereof, to-wit, the shreds and clots which are prone to remain in an atonic uterus. A too implicit confidence in the possibilities of antisepsis is apt to cause inattention to a very simple but efficient means of prophylaxis, namely, the complete evacuation of the uterus, and the securing of its normal firm, tonic contraction. We firmly believe that a failure to secure the firm and permanent board-like feel of the womb after the removal of the placenta and after a sweep of the cavity with two fingers for the removal of possible shreds, is at the bottom of the majority of cases of puerperal septicemia. This hard, board-like feel ensures complete expression of clots and

thorough closure of the sinuses, the patency of which in the large, flabby uterus favors the retention of clots and affords a favorable surface for absorption in the event of their decomposition. To secure it the exhibition of a drachm of ergot within ten minutes of the final throe of labor and the introduction of the two fingers for the double purpose of titillating and removing clots are the most efficient means.

Antiseptic midwifery proper, consists in the frequent and thorough washing out of the cavity of the uterus and vagina with disinfectants or antiseptics, the application to all rents or abrasions of the cervix uteri, vagina or vulva, of a strong solution of carbolic acid and the closure of the vulva by a napkin which has been thoroughly disinfected. The antiseptic injections thus far recommended are chiefly carbolic acid, permanganate of potash, iodine, corrosive sublimate, and sulphurous acid. The impracticability of these means in detail, for prophylaxis in general practice, must be apparent on the slightest reflection. A modification might, however, be introduced with advantage, and thorough disinfection of the accoucheur's hands, occasional washings of the vagina, and the antiseptic napkin, might be resorted to without impressing the patient with a sense of useless meddlesomeness and fussiness on the part of the attendant.—*Medical Age.*

On the Prevention of Laceration of the Female Perinæum.—Mr. Alex. Duke, M.K.Q.C.P.I., Obstetric Physician to Dr. Stevens' Hospital, Dublin, remarks, "The best preventive treatment of laceration that I have found (and which I dare claim as original, though I find no notice of it in the text-books on midwifery) is this:—When I find the head fairly engaged in the pelvis, and advancing with each pain, I take my seat by the patient's bedside, and having lubricated my left thumb, or the two first fingers of my right hand, I introduce either into the vagina, and at the onset of a pain, draw back the perinæum firmly, but gently, towards the coccyx, relaxing the tension gradually as the pain lessens till the next ensues, and so on till I can draw back the perinæum with very slight effort. I thus tire out the muscular structure, and produce sufficient relaxation for the had to pass.

"In most cases so treated there is no danger of the perinæum, but when the pubic arch is narrow (which can easily be determined) I take the additional precaution of raising the patient's left hip, and supporting it on a hard pillow, while the shoulders are kept low, fomenting the parts, using inunction of lard or vaseline, and taking particular care to direct the head forward by pressure, with my left hand below the coccyx, or a finger in the rectum, leaving the perinæum untouched. It has always seemed anomalous to me that the perinæum should be expected to dilate on such short notice, namely, "the process of extension," while dilatation

of the os and cervix occupy such a considerable time, even with the additional help of nature's hydrostatic dilator, viz., the bag of waters.

"The drawing back of the perinæum produces no additional pain to the patient, as it is done during an uterine contraction, and I feel sure that if nurses and students were educated as to the proper way of preparing the perinæum previous to its distension with the presenting part, we should see and hear less of lacerated perinæum."—*British Medical Joural.*

Injections of Hot Water in Delivery.—The remarks of Dr. Beckingsale on the value of hot-water enemata in delivery, I can fully endorse. The stimulant effect of hot water on the uterine tissue, though slowly gaining ground, seems to be far from generally appreciated by the profession, far less than, from its efficiency, it deserves. I refer not only to rectal enemata, but also to vaginal and uterine injections. Indeed, I believe the beneficial effect of hot water is more readily obtained by injection per vaginam than per rectum. That such should be the case in rigidity of the os is evident; and unless fæces be present in the rectum, I give preference to vaginal injection, as being the more efficacious of the two. In post partum hæmorrhage from inertia of the uterus, no remedy is more certain and speedy in its action; so much so, indeed, that it is a matter of surprise it should not be more generally adopted. The following case served, perhaps, more than any, to impress upon us its superiority over the means in more general use.

After removing a morbidly adherent placenta under chloroform, the uterus failed to contract, and, while waiting for hot water, the hand was retained in the cavity of the uterus; suprapubic pressure, with friction of the abdomen, flipping with a wet towel, all produced the same effect—local contraction of the uterus, answering to the surface of the abdomen affected, but nothing more. The administration of ergot, owing to the persistence of anæsthesia, was inadmissible. On injecting hot water, however, a general contraction took place, expelling the retained hand almost immediately, and the hæorrhage forthwith ceased.

As the objections which have been urged against uterine injection may be obviated, and all risks reduced to a minimum by a careful performance of the operation, the following details may be found useful.

First, with regard to the necessary apparatus, a Higginson's syringe (those made in one piece are the best) and uterine tube, furnish all that is required. From the obvious risk of lacerating the uterine tissues (one fatal case in which the tube found its way between a portion of retained placenta and the uterine wall having occurred to my knowledge), the leaden tube may, with advantage, be dispensed with, and a perfectly harmless substitute improvised by adding two or three more eyes to a No. 12 flexible India-rubber catheter. This can readily be adjusted to

the nozzle of the syringe, and the whole packed in a small compass. Being firmly convinced that all manipulations within the uterus should be conducted antiseptically, as a prophylactic measure totally apart from its curative influence in cases of intra-uterine decomposition, I invariably add Condy's fluid to the water injected. This may be carried in the form of powdered crystals of permanganate of potash, and added to the water as required, the strength (insufficient to stain the finger-nail) being readily gauged by the tint of the solution. This antiseptic being inodorous, nonpoisonous, readily portable, comparatively inexpensive, and losing its red tint, if slowly injected, only so long as there is decomposing matter in contact with it, is so suitable, that I need mention no other. The water should be of such temperature that the finger can be retained in it without producing pain.

The patient being brought into a good obstetric position, the trunk across the bed, with the buttocks well to the edge and the knees drawn up, the catheter and syringe being first filled with water, the tube can be readily passed in the following way. The point of the catheter should be taken between the tips of the first and second fingers of the left hand and inserted into the vagina. Before proceding further, the vagina should be flushed; the fingers then carried up to the os, acting as a guide to the point, the stem of the catheter, running along the cleft of the fingers and palm, is readily pushed onwards into the uterus. The injection, like all other intra-uterine manipulations, should be slowly performed, and the catheter moved from time to time, to bring the fluid injected into contact with all parts of the uterine cavity. Care should be taken, by keeping the end of the syringe beneath the water, to avoid the introduction of air. A siphon arrangement, made from a length of tubing, with spring clamp to regulate the flow from an elevated vessel, has been recommended in place of the syringe; but, though it answers very well as a permanency in the wards of a lying-in hospital, it will be found far from easy in manipulation in general practice.– *British Medical Journal.*

Means of Provoking the Secretion of Milk.—When the milk-secretion is slow in appearing in a lying-in-woman, or when it ceases from mental or moral causes, it may be made to return by cataplasms or fomentations of castor leaves applied to the breast, or by suction of the nipple, or by means of electricity. The mammary gland is slightly compressed between two sponge electrodes, and a feeble current passed through the gland for ten or fifteen minutes. This may be done twice a day. After the first few electrizations, the breasts swell, the large veins appear on the gland and the milk secretion is set up.—*L' Union Méd.—Medical Progresss.*

II.—GYNECIC.

A Trustworthy Combination of Coca, Viburnum and Celery:—With notes of cases, by William B. Hazard, M. D., Professor of General Pathology and of Diseases of the Mind and Nervous System, St. Louis College of Physicians and Surgeons; formerly Superintendent and Physician to St. Louis County Insane Asylum; late Consulting Physician to St. Louis City Hospital, Department of Nervous Associations, Etc.

Erythroxylon Coca is a shrub growing in several of the States of South America. The leaves are the parts of the plant used as a nervous stimulant or tonic. A large amount is collected annually by the natives and preserved for use by being dried in the sun. They are oval in shape, about two inches in length, and have a bitter and pungent taste when green; when dried, they taste like Chinese tea. The natives' method of use is by chewing the leaves mixed with a little ashes or lime.

The leaves contain coca-tannic acid, a variety of tannin which gives a green reaction with salts of iron; cocaina, a fixed, crystallizable alkaloid which benumbs the tongue and has a bitter taste; and hygrina, a volatile alkaloid, pale yellow in color, oily in consistence and possessing an alkaline reaction and a burning taste.

The physiological actions of coca upon animals are as follows: In small doses it dilates the pupils, causes hyperesthesia and loss of co-ordination of movements. In medium doses, it lessens, and then abolishes sensibility. In large doses, it produces tetanic convulsions.

In man, all authorities agree that it prevents fatigue and enables the user to perform more labor with less exhaustion than would otherwise ensue. The natives of South America, at the time of the Spanish conquest, claimed for it a divine origin. This caused the conquerors to interdict its use; but these religious scruples gave way before the fact that the enslaved populace could perform much more labor with than without it—a strong testimonial to the benefits it confers upon its consumers. The results of experiments made in this country are that coca retards, in some way as yet unexplained, tissue metamorphosis, and consequently diminishes waste, while, at the same time, it stimulates the nervous system without subsequent ill effects.

The medicinal virtues of coca are faithfully outlined in its physiological action. It is indicated in all functional affections in which it is a desideratum to prevent waste of muscular or nervous tissue. In all such conditions this agent becomes a valuable aid to conservative medicine. More effective than tea or coffee, and devoid of the pernicious properties of alcohol or opium, it gives the patient a respite from suffering and gives the physician what he most needs; *time* in which to obtain the reparation of worn-out physiological units of the organism through the agency of improved nutrition.

In the treatment of the alcohol and opium habits, coca has proven itself simply invaluable. Nervous exhaustion, whether superinduced by too prolonged brain-work, business worry, or excesses in venery, finds in coca a valuable help toward a restoration to the normal condition. In convalescence from acute diseases, this again becomes a valuable aid by hindering excessive waste of the body and giving time for the digestive organs to supply new material for the restoration of the exhausted organism.

There is a large class of cases which require something more than a mere nervous stimulant, although the principal symptoms are those of nervous exhaustion. Reference is here made to those instances of disease, which in the female are accompanied with pelvic pain, and, in the male, with urethral and prostatic hyperesthesia, and in both sexes with depression of spirits amounting to hypochondria reaching almost to melancholia. These cases require a sedative effect to be exerted especially over the reflex apparatus of the genito-spinal and abdominal sympathetic systems.

The varieties of *Viburnum* (*V. opulus* and *V. prunifolium*) have the power of reducing hyperesthesia and reflex excitability—in these directions. Ovarian neuralgia tending to abortion and dysmenorrhœa in the woman, and prostatorrhæa, psychical impotency and numberless symptoms of exaggerated irritability of the sensory nerves in the man, are happily relieved by preparations of *viburnum*.

Celery (*Apium graveolens*) has long been recognized as possessing strong powers as a diuretic, at the same time controlling irritability of the bladder, and exerting a most beneficial influence over headaches of nervous origin. As a soothing agent in sleeplessness originating in overwork, and as a stomachic tonic, when taken in moderate quantity after meals, aiding in digestion and assimilation, popular favor has long since marked it out as "a friend in need" to the nervous dyspetic as well as to those whose appetite tempts to over-indulgence at the table. Celery, when taken in substance, or if the stalks are not properly blanched, often acts disadvantageously, especially if it is hastily swallowed without proper mastication. This may be avoided by the use of a fluid extract. The bane of American life is dyspepsia, which has gained recognition as *the* American disease. Good cooking and sufficient mastification of food would do much to overcome this national enemy. But we have to take things as we find them, and the average American has to have a stomachic stimulant or tonic furnished him to overcome the effects of a bad *cuisine* and worse habits as regards the pursuit of business as well as ingestion of food. In Richardson's "CELERINA" we find a combination which very fairly meets the requisites hereinbefore pointed out. As a tonic and soothing agent, acting primarily upon the digestive and genito-urinary systems, and as a modifier of the nutrition of the nerves supply-

ing the pelvis, it is, theoretically, well calculated to meet a large class of indications. Practically, it has proven itself worthy of a more extensive trial than it has yet had from the medical profession.

My own experience with "CELERINA" has, thus far, been rather limited. In two cases of dysmenorrhœa, accompanied with ovarian hyperesthesia, due to excessive child-bearing and over-work at the wash-tub, and consequent loss of appetite and emaciation, "CELERINA" afforded marked relief. These were charity cases and, consequently, not very favorable subjects for treatment. Under better circumstances, I am satisfied that permanent relief would have resulted.

A case of the most marked nervous exhaustion, consequent on prolonged masturbation, resulting in temporary impotency, was referred to me by a physician in Central Texas, in the summer of 1882. The patient was a very intelligent gentlemen of thirty-two years of age; single; hypochondriacal, and low-spirited almost to the verge of suicide. Treatment by strychnia, phosphorus, laxatives and local applications to the neighborhood of the prostate gave him no relief. Cold baths and a general tonic regimen were equally without result. He was finally given two pounds of "Celerina," with directions to take two teaspoonfuls after each meal, which were faithfully carried out, and a cure was effected.

The first result to be achieved in the treatment of such a case, is to secure complete abstinence from the vile practice which was the primary cause of the trouble. This is often beyond the enfeebled powers of the patient, unless he has proper medical aid. I think the effects of viburnum, in this regard, by soothing the urethral mucous membrane and counteracting the "irritable weakness" of the genito-spinal center, may be safely relied upon in cases where there is any amount of will-power available. In a second case referred to me in October, 1882, by a physician of Southern Kansas, there was less marked hypochondria, due to indigestion, constipation, and lack of out-door exercise. Here a proper laxative, horseback exercise, and regulated diet produced some improvement, but the mental depression was not relieved until the second eight ounces of "CELERINA" had been nearly exhausted.

In February of this year, an old gentleman from Southern Arkansas, the subect of attacks of melancholia recurring every two or three hours, presented himself to me for treatment. His then present attack was marked by no definite delusion, but by such a profound depression of spirits that he could scarcely refrain from committing suicide whenever the surrounding circumstances would give him the opportunity to take his own life. Although a man of wealth, he feared impending poverty, at the same time recognizing the folly of such fears. Laxatives, cannabis indica, bimeconate of morphia, and a hydrotherapeutic course did him no good. He greatly improved on "CELERINA," and at last accounts seemed fairly on the road towards recovery. His digestion and sleep

were greatly improved by this preparation, and I consider it added to make his condition more tolerable; at the same time I believe he would have recovered, as he had on three previous occasions, without much medication. It is possible, however, that he avoided commitment to an asylum by the use of the medicines prescribed, something terribly humiliating to a proud and sensitive spirit such as that possessed by this gentleman, as well as agonizing to his relatives and friends.

The excessive wear and tear of the muscular system during an attack of chorea and after rapidly recurring epileptic paroxysms, as well as during delirium tremens, would doubtless be diminished by the judicious use of this valuable agent.

I trust the profession may be induced to give this combination of excellent remedies a fair trial in properly selected cases. I know the honorable character of the manufacturer, and that reliance can be placed implicitly upon the purity and genuineness of the agents entering into its composition.

The protest of the profession has always been uttered against "secret nostrums" and "patent preparations," in neither of which category can this combination of well-known, recognized drugs in definite proportions, be classed. The "howl" against "trade-mark articles" is clearly unjust, when, as in the present instance, the trade-mark is a guarantee of trustworthiness.

5 S. High Stree, St. Louis, Mo.

Treatment of Carcinoma of the Cervix.—Dr. Karl Pawlik (*Weiner Klinik*, December, 1882,) has in this monograph thoroughly studied those cases of carcinoma of the cervix which have been operated on in the first gynecological clinic at Vienna by the galvano-caustic wire. As regards this method of operating the author by no means advocates it as the best. On the contrary he thinks the knife and scissors an equally good method. He has, however, found the results to be so satisfactory with this method that he publishes these statistics with the hope that the publication of large numbers of cases operated on by other methods may lead to a comparison of the ultimate results, and some more definite idea of the relative value of the different methods of operating. His main reason for preferring the knife to the galvano-caustic wire is the complex character and expense of the instrument which make it practically useless outside of large institutions. Hemorrhage, he claims, can be as perfectly controlled by one method as the other. When the disease is high up in the cervix the knife can reach it better, and the author justly says it would be very short-sighted in so grave a disease as carcinoma to depend exclusively on one or the other method. He lays considerable stress upon the value of the slough, and would have cauterization follow the operation with the knife.

The cases cited show that the simple amputation of the cervical disease is followed by better results than the extirpation of the uterus. As it seems probable that in many cases the disease if left to itself spreads into the body of the uterus, when the extirpation of the whole organ as a prophylactic measure is unnecssary. In deciding which operation is best there is one point upon which the author justly lays weight, namely, that it does not always follow that because we find thickening in the neighborhood of the uterus and enlarged glands they are necessarily the result of infection. They may be simply the result of irritation, and post-mortem examinations have demonstrated this.

The following are the results of the 136 cases which the writer has collected:

Ten cases died in the hospital; one almost four months after the operation from recurrence of the disease; one case twenty-five days after operation from marasmus; eight after the operation; three of anæmia; and five of peritonitis.

Twenty-two cases could not be found; of two, however, it was known that they were in good health two years after the operation.

Sixteen cases left the hospital not cured.

Thirty-one cases died outside the hospital; sixteen of these had in all probability a recurrence of the disease, one after three years; one had a return near the uterus two years after the operation, the cicatrix remaining unaffected; three died of tuberculosis; for the rest the cause of death was unknown.

Twenty-two cases had a recurrence of the affection, but it was not possible to discover when they died. Among them was one who remained in good health for six years, and one for nineteen months. Two had carcinoma outside the uterus, the cicatrix remaining unaffected.

Two died in childbed, without recurrence, one seven and one half years, and the other one year after the operation.

Thirty-three cases were in good health:

1	19½	years after the operation.
2	12	years after the operation.
3	8	years after the operation.
3	7	years after the operation.
3	5	years after the operation.
2	4	years after the operation.
5	3	years after the operation.
7	2	years after the operation.
7	1	year after the operation.

The author then gives a description of the method of operating and some of the complications. The peritoneal cavity was opened thirty-nine times in the posterior cul-de-sac, and once both in front and behind. Four of these died, two of anemia, and two of peritonitis.

Hemorrhage occurred during or immediately after the operation six times; checked five times by iron cotton, and once by the actual cautery. In thirteen cases secondary hemorrhage occurred; in three vesico-vaginal fistulæ, one of which was due to a rapid recurence of the growth. In two cases only did parametritis follow.—*Boston Medical and Surgical Journal.*

A Sharp Spoon in Gynecology.—A recent number of the *Archiv für Gynäkologie* contains an excellent article by Dr. v. Weckbecker-Sternefeld, of Munich, on the use of the sharp spoon in gynecology (*Medical Times and Gazette*). This writer's statements are based upon experience, for he gives a table and careful analysis of one hundred cases in which he has used the instrument which he recommends. In this absence of haste, it would be well if his example were more generally followed; for we have known instruments exhibited and lines of practice laid down by men who had never once used their instruments, or seen a case calling for the practice they write about. The cases in which Dr. v. Weckbecker-Sternefeld advises the use of the sharp spoon (which, we may mention, is that known as Simon's) are these: In abortion, when the ovum or membranes, or part of them, are from any cause retained in utero; in cases of mole, vesicular or fleshy; after labor, in cases of hemorrhage or fetid discharges, caused by retention of bits of placenta or membranes, or polypoid growths at the placental site. The advantages of the sharp spoon as compared with the digital detachment and removal of such offending bodies, he thinks, are these: avoidance of septic infection; the small space required for its use; the completeness with which detached bodies can be removed in the hollow of the spoon; the almost painlessness of the proceeding for the patient; the absence of dragging upon the uterus, and the unirritating character of the proceeding. The instrument is used, of course, in the same way as the curette; it may in fact be regarded as a large curette, so shaped as to be capable not merely of detaching, but of bringing away any mass loosely attached to the uterine wall. The size of spoon which Dr. v. Weckbecker-Sternefeld finds most generally useful is about an inch long by rather more than half an inch across. The angle at which the spoon is set on the handle matters little, but it is convenient to have the direction of the convexity and concavity of the spoon indicated by marks on the handle. Its use does not give pain enough to make anesthesia necessary. Our author, as we have mentioned, gives a careful analysis of one hundred cases in which he has used a sharp spoon. Of these, in nine it was employed for the removal of an ovum in process of expulsion; in thirty-one for removal of membranes, or portions of them, after the embryo had been discharged; in twenty-seven for removal of placenta, or portions of it, after premature delivery; in twenty-eight, for the same purpose after

delivery at term; in two for atony of the uterus post-partum; and in the others, for endometritis, deciduoma at the placental site, placental polypus, fleshy and hydatid mole. Of the one hundred cases five died; three from puerperal septicemia existing before the operation was undertaken, one from enteric fever, one from peritonitis. The last mentioned our author considers the only one in which the fatal result could be connected with the operation, but in this there was also some disease of the rectum, and a previous attempt had been made to effect manually the object for which the spoon was used. In most cases no bad symptoms followed, and the patients quickly recovered.—*Louisville Med. News.*

Herniaria Glabra, besides being of benefit in acute cystitis of the neck of the bladder, has been used successfully in chronic cystitis and in the bladder and urethral troubles attendant upon certain conditions of the womb and vagina.

It seems also to possess an important preventive action in cases of gonorrhœa, *i.e.*, it limits the inflammation to the anterior portion of the urethra, and renders less liable the extension of the disease to the deeper part of the urethral canal, its adjuncts and the bladder. It has been used by one physician in thirty cases of gonorrhœa, and in none of these cases has the inflammatory action passed deeper than is ordinarily found in a simple case of this disease. This preventive action will, as a matter of course, render far less probable that disagreeable but common accompaniment of gonorrhœa, epididmymitis.—*Cincinnati Lancet & Clinic.*

III.—DISEASES OF CHILDREN.

Palatable Drugs for Children. — Frederick Churchill, M. D., F. R. C. S., Surgeon to, and Member of the Drug Committee, Victoria Hospital for Children, contributes the following to the *British Medical Journal:*

We owe it, probably, much to the persistency with which practitioners of the sterner sort have impressed their rhubarb and black draughts upon rebellious children, in defiance of the protestations of nurses and mothers, that "the tasteless globule" has found such favor with the weaker sex. I could tell of several cases where the children have been entrusted to the care of a homœopath, while the parents luxuriate under the usual heroic treatment of the orthodox practitioner. We must not forget to swim with the tide. Children of this enlightened age are far more pampered and spoilt than those of the previous generation. Mothers seem unable to control their feelings; or, it may be, that, with a smattering of physic-lore, they find that there is no longer any necessity to cling to the once inevitable and nauseous potion. We must say a word, too, for the children. None of us like compulsion. It must not be forgotten that

there is often more harm done to a child's nervous system, by cramming the draught down its throat, than all the good the nauseous drug was supposed to effect. Children will often take days to recover their equilibrium after a protracted encounter with the medicine-glass in the nursery, under the stern discipline of a would-be conscientious nurse. Judging from the varied susceptibilities and dispositions of the children under my care, some of them having very resolute wills, others possessing—I cannot say endowed with—mothers of a pronounced æsthetic temperament, to whom everything is a bore, except a novel to read and a sofa to lie upon, it becomes most important to formulate a line of treatment that will satisfy such requirements.

This class of children are generally ruled by a domineering old woman they call "nurse", displaying a maximum of "tall talk", with a minimum of what she delights to call "common sense" (and very common, indeed, it proves to be). The medical man must cultivate a habit of attacking such a stronghold of prejudice and conceit by a series of carefully planned flank movements, in such a way that the nursery magnate may be drawn, against her own convictions, into a pliable frame of mind, sufficient to enable the medical man's physic and regimen to stand a chance of being attended to.

To attempt to invade the sanctum of a nursery where the lady-paramount is cajoled into the idea that "nurse is a treasure", and prefers rather to foster the notion, than to care to have her eyes opened to the actual state of reigning ignorance, requires all the practical art of the medical man gradually to overcome and remedy.

Undoubtedly the ailments under which children for the most part suffer, belong to the preventable class. They are due sometimes to overfeeding; very often to neglect, especially of the calls of nature; and very much to general bad management. With this view, it may be well to presume that the best and most approved mode of treatment for habitual torpidity of the bowels is not medicine, but an enema of soap and water, with occasionally a little castor or olive oil added to the injection. If this do not succeed, and the child's appetite begins to fail, it is an indication for administering medicine by the mouth.

Fortunately, the art of the apothecary comes in to our aid, and we are now enabled to give the most nauseous of drugs—castor-oil—absolutely free from taste and smell, while it retains the full aperient properties of ordinary castor-oil. Messrs. Allen and Hanburys themselves advise that it should be shaken up with three or four times it bulk of hot milk. The viscidity of the oil is thus avoided, and the emulsion produced is scarcely distinguishable from warm rich milk.

If it be desirable to administer an aperient that will act more directly on the liver, and to avoid the unpleasant effects which often arise after taking "oil," the compound rhubarb pill will be found a servicable

aperient. Of course, some new method for its administration will be desired, which I shall now detail. Either an ordinary five-grain pill may be cut up, and a portion of it broken in small pieces may be buried in a chocolate cream, which the youngest child will take with avidity; or for children of, say five years and upwards, I have given one-half and one-fourth of a grain of this pill, thinly coated. Half-a-dozen or so may be taken, like "hundreds and thousands," and washed down with milk or water.

The medicated fruit lozenges are very useful, *e.g.*, tamar indien and laxora lozenges. Podophyllin is probably one of the active ingredients in these lozenges. Only a small portion of a lozenge must be given to a child. The objection found with these is that they sometimes "gripe" the little patient. Next to these, perhaps, in efficiency and palatability is the compound liquorice powder, containing senna powder. About a teaspoonful stirred up with warm milk may be taken at bedtime, and a little chloric ether added (about ten to twenty drops). Very few children will object to take fluid magnesia or the calcined magnesia, especially if flavored with the syrup of mulberry or orange.

I have succeeded in making the taste of many powders by the addition of powdered "rose" lozenges. I very seldom prescribe Gregory's powder on account of its nauseous character and bulk. I prefer to combine the rhubarb with bicarbonate of soda about five grains of each. This makes a much more miscible and manageable powder. Given in jam, honey or golden syrup, the taste is altogether covered.

Children will sometimes take the "baume de vie," or decoction of aloes, without objecting much. A little of this rubbed into the stomach of infants will suffice sometimes to procure an action of the bowels. The extract of liquorice may be added to the decoction until the bitter taste is sufficiently masked. Children have not really such an aversion to it, for I have known them to lick off the aloes from their fingers when put on to prevent them from sucking them. Powdered aloes, about half a teaspoonful, may be given mixed with brown sugar. The electuary of senna is taken without difficulty by some children, also the syrup of senna and the infusion with prunes. The effervescing purgative lemonade is a very agreeable drink, as also half a Seidlitz-powder flavored with lemon-juice.

Turning now to febrifuge mixtures, there is not much need of flavoring to mask the flavor of these. Sweet nitre, acetate of ammonia, spirits of chloroform, are all pleasant drugs to take. The nitrate and chlorate of patash are rather saltish, but the sal prunelle and Wyeth's compressed tablets will be taken by the bigger children without much protest. The syrups of orange, lemon, and mulberry, will come in as agreeable and cooling adjuncts. Cough-mixtures can generally be made very pleasant by the addition of syrup of squills, of tolu, etc.

As regards tonics, some considerable skill will be necessary efficiently to cover the bitter flavor. Children will take the saccharated carbonate of iron very well, and also steel wine; but if we attempt to give the bitter infusions, there is sure to be rebellion in the nursery. Quinine—one of the most valuable medicines for children—can be given without difficulty, either in the form of pill or, which I prefer, dissolved in syrup of orange, without the addition of any water. This effectually covers the flavor. Quinine wine is useful for the elder children.

Chemical food is, of course, taken with relish, and if recently made is a serviceable tonic; but the phosphate, from their insolubility, throw down very much. The compound solution of the hypophosphites, in ten-minim doses, and the hypophosphite wine, forms a perfect substitute for Parrish's food. Besides having iron in a form which is easily absorbed, the hypophosphite of magnesia serves as an useful antacid and stomachic in this combination.

With a view of putting into practical form these two suggestions, and to systematize the irregular but constant attempts of mothers to keep a little dispensary of their own, I have instructed Messrs. Savoy and Moore to fit up a nursery medicine-chest, with a companion guide, to assist mothers, especially those residing in the colonies and far away from medical aid, to treat their own children in such emergencies.

Melæna Neonatorum.—Dr. Epstein, of Prague, discusses this subject (*Allgem. Wein. Med. Zeit.*, No. 49, 1882), and points out that the occurrence of hemorrhage from the stomach and intestines of new-born children is by no means uncommon. He considers that a distinct disposition to hemorrhage from various organs must be recognized as belonging to the first few days of life. This disposition is made manifest or increased, when either disturbance of circulation, or disease of vessels, or of the blood itself, is present. The notable alteration in the circulation which takes place at birth must therefore be regarded as a principal cause of the hemorrhage, and especially in cases of protracted labor, or of children born in a state of partial asphyxia, or of weakly children with atelectasis of the lungs. Various conditions have been found in the gastro-intestinal mucous membrane: hyperæmia, hemorrhagic erosions, ulcerations, and actual hemorrhage. In many cases, where the mucous membrane of the stomach has been found sprinkled with small ecchymoses, small rounded ulcers have been discovered; and these have by some authors been regarded as the real cause of melæna neonatorum, the ulcers themselves being brought about by thrombosis or embolism of the gastro-duodenal vessels, secondary to thrombosis in the umbilical vein. This is probably, however, the rarest cause for the hemorrhage; the most common cause being the hyperæmia and temporary congestion of the finer capillary vessels. Although ulceration may take place with extreme

rapidity after birth, it would appear that it is usually of intra-uterine origin; and several cases are recorded, where such ulceration has led to actual perforation of the intestine or stomach. Another group of cases is formed by those of children infected with septic diseases or the subjects of hereditary syphilis. In the latter cases the hemorrhage may be the only evidence of the disease, the liver being found free from any syphilitic mischief. In the cases in this group, the prognosis has been clearly shown to be unfavorable. About half of the cases end fatally, and the immediate cause of death is usually the hemorrhage itself. A few cases, however, recover with marked rapidity.

Prof. Widerhofer records an interesting case of melæna neonatorum (*Allgem. Wien. Med. Zeit.*, No. 4, 1883), in which syphilitic manifestations were very distinct, and where hemorrhages had taken place from other than mucous surfaces, the case in many respects reminding one of hæmophilia or of purpura. Such cases he regards as due to the specific affection of the blood. The prognosis is bad, and treatment by hæmostatics is of no avail.—*London Medical Record.*

Education of Children.—It seems to us very clear, says the Medical Times, that in the modern system of perpetual examinations, and especially of competitive examinations there lurks a very serious danger. All education should have for its object the training and development of the mind rather than the acquisition of facts; whereas very often, if not usually, in these competitive examinations it is the amount of facts crowded into the mind at the time of examination which is the basis of judgement.

The tendency to teach children many things imperfectly rather than a few things perfectly is but too apparent in our schools. Another more serious error, which is closely connected with many studies and long hours, is the teaching children to dawdle over the books. It is the exceptional man who will stand more than four or five hours a day of intense mental application; and yet the pulpy brain of the child is kept fuming over the books this length of time in school and two or three hours more out of school. Four hours a day for a child of fourteen years is sufficient; but the attention should during this time be kept fixed upon the subject, and the habit of close study thus acquired will be far more valuable than the primary knowledge taken into the brain. Short hours and intense application to a few studies are the foundation of an ideal school. To carry it out it is necessary that the classes be small enough for personal instruction.

The Use of Quinine in the Diseases of Children.—M. Jules Simon, of Paris ("*Revue des maladies de l'enfance*," February, 1883), calls attention to the necessity of bearing in mind the curious and unexpected forms

in which malarial poison manifests itself in children no less than in adults. The obscurity of the malarial origin is often greater in cases affecting children than in those affecting the mature. Not only may there be no fever, but there may be no periodical exacerbations of the disease. There may be no reason to suspect the true nature of the attacks, except the history of exposure in a malarial region. Nevertheless, if the affection be due to malarial poison, all treatment that does not take the cause of the disease into consideration will signally fail, while quinine will effect the most astonishing cures. M. Simon cites four cases of children suffering from irregular forms of malaria, some of which had resisted all other treatment, all of which, however, yielded quickly to the sulphate of quinine.—*New York Medical Journal.*

Gossip.

INFANTILE MENSTRUATION.—Dr. Vanderveer, of Albany, N. Y., reports to the *American Journal of Obstetrics*, for September, a very remarkable case of menstruation. The child began to have a regular flow when she was only four months old; at the date of the report the child is two years and seven months old and has regularly menstruated every twenty-eight days since its first appearance. She now (Sept., 1882) weighs forty-nine pounds. Features and form that of a girl ten or twelve years old. Her mammary glands are as large as a small orange. The mons veneris is well developed and covered with full growth of hair. The external labia large, and all parts of the vulva fully formed. She is bright and intelligent, but easily irritated, especially at the beginning of the menstrual epoch. Her appetite and tastes belong to a child much older.

December, 1882, and January and February, 1883, she did not menstruate, and her actions was very much more fretful, and inclined to be wakeful at night. March, 18, it came on again as of old and has been normal since, she appearing better in her disposition.

This is one of the very unusual abnormal cases. We have a few on record that are somewhat parallel, but the unusual character of these exceptional cases will command our respectful study.

A Case of Porro's Operation in Philadelphia.—On Friday of last week Dr. W. H. Parish performed Cæsarean hysterectomy at the Almshouse Hospital in Philadelphia, that patient being a dwarf. The woman survived until Monday, and at last accounts the child, which weighed six pounds, was doing well. The case seems to have excited considerable interest in Philadelphia, not only among the profession, but also among

the newspaper reporters, judging from the head-lines, "Wonderful Surgery," "The Modified Cæsarean Section Successfully Performed," etc., together with their detailed accounts of the steps in the operation, and the long lists they give of the physicians present. After all that, it seems somewhat cynical for the "Evening Post" of this city to record the woman's death under the caption, "The Victim of a Surgical Operation."

Esthetic education, especially when not accompanied with special discipline, tends to increase inherited habits until the existence of some persons consists of successions of nerve-center explosions—with all the prodigal waste of energy which accompanies that state—where mere pulses would answer much better. Such a person is thrown into ecstasies of pleasure or pain by causes by which a balanced temperament would not be affected.—C. Fayette Taylor in "*Sensation and Pain.*"

A New Professor of Obstetrics at Jefferson College.—Dr. Theophilus Parvin, of Indianapolis, who for some years has been a member of the faculty of the University of Louisville, has been elected Professor of Obstetrics and Diseases of Women and Children in the Jefferson Medical College of Philadelphia, succeeding Dr. Ellerslie Wallace. We congratulate Jefferson College on the acquisition of Dr. Parvin, who has long been favorably known as an obstetrician.

Her Royal Highness Princess Christian, of Schleswig Holstein (Princess Helen, of England, has) received a diploma as "nurse," having attended the course of lectures and passed the examinations at Kensington Center Institution. This is the lady who translated the little volume entitled, "Early Aid in Injuries and Accidents," by Prof. Esmarch, who, by the way, is her brother-in-law.

Dr. D. A. Morse has established a most capital private asylum for the insane at Oxford, Ohio. His experiences being complete, as he has been connected with the asylums at Columbus—Dayton as Superintendent—we wish him great success.

Dr. Geo. F. Schrady, of the *Medical Record*, has our sincere and personal sympathy in the loss of his wife, an estimable woman, that meets the Scripture demand.

It was Garrick who wrote the following famous epigram on Sir John Hill:

"His physic and farces
His equal there scarc is,
His farces are physic,
His physic a farce is."

THE Australasian Journal is responsible for the following story: A man who had lived for some time among the shakers in New Caledonia, left the tribe and killed two men who were sent to bring him back. The natives were greatly incensed, captured the man and—ate him. But every one who shared in the repast died with symptoms of poisoning, the man having been syphilitic!!!

DR. OLIVER WENDELL HOLMES declares that the great secret of success in every form of quackery is hope kept alive in the patient; while the too fatal gift of science is a prognosis of despair.

Married.—At Cincinnati, O., July 26, 1883, by the Rev. Dr. Rowland, Professor Samuel G. Armor, of the Long Island College Hospital, Brooklyn, N. Y., to Mary T. Yorke, of Cincinnati.

Bibliography.

Types of Insanity. An Illustrated Guide in the Physical Diagnosis of Mental Disease. By ALLEN MCLANE HAMILTON, M.D., one of the Consulting Physicians to the Insane Asylums of New York City, etc. New York: Wm. Wood & Co. 1883.

This is rather an unusual work, but certainly a very excellent one; when we say "excellent" we mean to say that Dr. Hamilton has contributed a monograph that is out of the usual line and is to be regarded as strictly original. The work consists of *Ten* plates illustrating various phases of mental disease. These cases were studies in the New York Insane Asylum and the illustrations are all wonderfully expressive. Each plate is accompanied with suffiicient letter press to explain the peculiarity of the individual patient. Together with the plates and explanation is a very lucid essay in five chapters, which give the following studies, we give them in full:

1. General appearance of the Insane—Physiognomy, Posture, Conformation of the Head, etc.

2. Condition of Special Organs: The Eyes, the Ears, the Mouth and the Teeth, the Tongue, the Nose, etc.

3. Condition of the bodily functions: Circulation, Temperature, Pulse, Skin and Appendages; Muscular Tonus; the Reflexes, Urinary Secretions, Menstruation, etc.

4. Examination of the patient. Changes in Chest. Hand writing of the Insane.

5. Commitment of the Insane. Laws of the various States.

Now all this seems a large field upon which to remark, and yet Dr.

Hamilton has compressed all of importance in a very few pages. Some of these chapters are of peculiar importance to almost every practitioner. Chapter IV., for example, is of special interest to almost every doctor, because almost every doctor is sooner or later called to express an opinion on insanity, and woe be to him if he is not correct. Dr. Hamilton's suggestions will help any poor doctor thus called to the Probate to decide such nice questions.

Of course Chapter V. is only a resumé of Law, and yet it is well that the examining physician should know what he is doing.

Medical Essays, 1842–1882. By OLIVER WENDELL HOLMES. Boston: Houghton, Mifflin & Co. New York: 11 East Seventeenth Street. The Riverside Press, Cambridge. 1883. Price $2.00.

Amongst the many new books presented for professional reading and regard nothing equals this volume of essays by Dr. Holmes. Most of these essays have been long time familiar to us, for example the incomparable essay on the *Contagious Character of Puerperal Fever*. Long ago we had occasion to use this essay to good advantage in the discussion of this vexed subject. So too other topics treated in this volume we have enjoyed in days past! But—we take up the volume and read a page here and there and while the pen is fresh we unconsciously go on and on reading and forget the critic's duty.

The book contains nine essays: Homeopathy and its Kindred Delusions; The Contagiousness of Puerperal Fever; Currents and Counter Currents in Medical Science; Border Lines of Knowledge, etc.; Scholastic and Bedside Teaching; Medical Profession in Mass.; The Young Practitioner; Medical Libraries; Some of My Early Teachers.

We commenced a notice of this book—then we commenced to read. The more we read the more we felt we hadn't time to bother with any review. So we say to our friends buy the book, read these essays and enjoy them, and profit by the nuggets of wisdom they contain.

The mechanical execution of the book, like everything which comes from this house, is very attractive.

A Manual of Obstetrics. By A. F. A. KING, M.D., Professor of Obstetrics and Diseases of Women and Children in the Medical Department of the Columbian University, Washington, D.C., and in the University of Vermont. Philadelphia: Henry C. Lea's Son & Co. 1882.

This little book has been in the hands of the profession for some time and has already had its endorsement. Most of the teaching portion of the profession has had the opportunity to judge of the value of the work done by Dr. King. We had expected a more pretentious book, but we are pleased at any rate with what we get. The volume is a manual,

almost of capacity to carry in the overcoat or buggy. At any rate this is a condensed volume in which the busy practitioner will find everything in the very briefest shape and so convenient of reference. It is well known by obstetric readers that Dr. King has had some peculiar notions in the management of midwifery cases – but these do not appear obtrusively in the book.

Now while Professor King gives the usual details of the management of labor, he proceeds as follows, in regard to the binder of the baby: "This old fashioned custom is by no means a good one. It is inconvenient, as well as uncomfortable and injurious to the child. If there be no defective development of the abdominal walls, the infant needs no artificial support by belly-bands, and the cord is better left without any dressing at all, except a little new cotton (borated or mildly carbolized) to absorb its moisture and prevent sticking to the clothing."

Any busy doctor who a wants hand-book for easy reference will do well to buy this book, he will find in it almost every suggestion for usual cases and for the unusual cases. The book is by no means what we had expected from Prof. King, but still it is a good book.

Treatment of Diseases of Infancy and Childhood, with over Four Hundred Formulæ and Prescriptions as Exemplified in the Services of Drs. Jacobi, Smith, Clark, Flint, Loomis, etc., etc. By CHAS. H. GOODWIN, M.D. New York: C. H. Goodwin, M.D., 245 West 53d Street. 1883. Price $2.50.

Dr. Goodwin inaugurates a new style of book making. He makes no pretentions to personal originality but proposes to give his readers the benefit of the various plans and methods of the leading gentlemen connected with the prominent New York hospitals. For example, say in the syphilis of infants, he gives the views and treatment of Smith, Otis, Taylor Fox, and Draper. So take diphtheria, we have the details of the treatment pursued by J. L. Smith, Jacobi, Billington, A. A. Smith, Delafield, Alonzo Clark, etc., etc. Now all these "*plans*" are to be accepted as so many views; very much as we accept the suggestions of a physician called in counsel. We have the benefit of a world of individual experience, and we must use our own judgment after all as so far as it is adapted to our particular case. Still it is suggestive.

Octerloney's Record of Obstetric Cases. Tabulated Record of Obstetric Cases. By J. A. OCTERLONEY, M.D., Professor of Obstetrics and Diseases of Women and Children, University of Louisville. Louisville, Ky., Jno. P. Morton & Co.

The advantage to be gained by medical men from recording their experience is too obvious to require mention. We all know that that physician does most good to his patients who carefully records each point

of their illness and the effects obtained by treatment. It is fully as important to do this in obstetric as in any other department of practice. The difficulties complained of, and usually given as the excuse for failing to record cases, appear to us to have been overcome in the record before us.

Columns are given for name, age, color, nativity, number of previous labors, date of last labor, number of premature deliveries, date of last, last menstruation, date of quickening, date of labor, presentation, position, sex and weight of child, duration of first, second and third stages of labor, also for remarks on the labor and puerperal state.

The record is so arranged that these columns can be very readily filled and we have no doubt it will meet with the ready sale it deserves.

A Practical Treatise on the Medical and Surgical Uses of Electricity. By GEO. M. BEARD, A.M., M.D., and A. D. ROCKWELL, A.M., M.D. With nearly two hundred illustrations. New York: Wm. Wood & Co., 56 and 58 Lafayette Place. 1883. Price $5.50.

This is the fourth edition of a very valuable work, that this very edition indicates as having received the stamp of professional approval. This edition has received the careful supervision of Dr. Rockwell, his associate, Dr. Beard, having closed up his professional work and gone to his reward. As this work is so well known to the profession, it is needless to give a synopsis of its material—it is, however, very complete—very excellent—everything that the practitioner can ask for as a guide to the use of electricity in medicine and surgery.

We cannot refrain from a hearty expression of the handsome work done by the publishers—the presswork—wood-cuts—and everything go to make up a handsome volume that the reader will enjoy.

A Text-Book of General Pathological Anatomy and Pathogenesis. By ERNST ZIEGLER, Professor of Pathological Anatomy in the University of Tubingen. Translated and edited for English students. By Donald Macalister, M.A., M.B., etc. New York: William Wood & Co., 56 and 58 Lafayette Place. 1883.

This is the July volume of the series of Wood's Library of Standard Medical Authors for the current year, and the publishers have exhibited their usual good judgment in the selection of this work.

The usual topics are discussed in this book, which pertain to this department of medicine. Perhaps the most interesting section of this book is the last devoted to *Parasites*. The whole subject of the *Bacteria*, the *Bacillus Tuberculosis* are included in this part of the book and this study alone will well repay the cost of the book. There are over 100 wood-cuts of good character, illustrating the more important parts of the text,